2004 Annual Patient Safety Report
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Executive Summary

Five years after the Institute of Medicine (IOM) issued its report To Err Is Human (1999) with the alarming statistics of medical errors in hospitals, the process of improvement continues to move slowly. As a result of this report more health care facilities are involved in extensive quality improvement efforts. Emphasis has been on changing the "blame game" to a systems approach and understanding the gravity of the problem. Research and work is still needed to demonstrate the use of technology in the delivery of health care such as the adoption of electronic medical records, bar coding, changes in medication administration process, team work training, and building a better patient-physician relationship.

2004 marked the second year of the implementation of the Health Data Reporting Act in Tennessee. The Department has worked extensively with all licensed health care facilities in the area of reporting requirements, conducting appropriate investigations and developing acceptable corrective action plans. The Department, Tennessee Hospital Association, Tennessee Health Care Association, Hospital Corporation of America, and other stakeholders worked together to provide the first statewide patient safety conference which was held on August 26, 2004 with over 400 individuals attending.

In accordance with the Tennessee Health Data Reporting Act of 2002, all licensed health care facilities are required to report to UIRS (Unusual Incident Reporting System) any occurrence of unusual events and identify measures to address the cause(s) of those events. For purposes of UIRS reporting, an unusual event is defined as "an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient that is not related to the natural course of the patient's illness or underlying condition". Facilities have the capabilities to query the system to find comparative data to use in internal quality improvement efforts and prevention. It must be noted, however, that many of the unusual events reported to the Department are not medical errors, but are other types of unusual events.

While all facility types have made strides in reporting of unusual events to UIRS, many improvements are still needed. Complete and accurate reporting is critical for UIRS data to be used effectively as a tool for quality improvement and error reduction efforts.

In this third annual report of unusual events/medical errors, the Department provides a compilation of information from 2004 reported events and from the 1998-2003 administrative data sets from hospital discharge data. This report also contains:

- Progress report of identified areas of improvement in 2003;
- Summary of patient safety indicator data identified by Agency for Healthcare Research and Quality (AHRQ), including a correlation between Tennessee hospital discharge data;
- Comparative reports received in each of the three grand regions of the state;
- Comparative charts of reporting methods by facility type and occurrence codes; and
- Continued areas of improvement

The Department's achievements in 2004 include:

- Increased reporting to UIRS from 3,805 in 2002 to 4,302 in 2003 to 4,908 in 2004, a 28% (twenty-eight percent) increase;
- Identified and implemented changes in UIRS software for increased user capabilities;
- Added current information to the Department's patient safety web page which provides a comprehensive look at the patient safety initiatives implemented in Tennessee.
- Awarded a grant to participate in patient safety training conducted by the Veteran's Administration and the Agency on Health Research and Quality (AHRQ).
- With assistance from Tennessee Hospital Association (THA), Tennessee Health Care Association (THCA), and Hospital Corporation of America (HCA) the first Patient Safety Symposium was held August 26, 2004.

The Department of Health, licensed health care facilities and health care professionals continue to face an enormous challenge in the area of patient safety. Although there continues to be resistance to reporting an unusual event both internally and externally to the Department, this may be from the process of changing human behaviors. However, we do recognize the increased reporting of unusual events in 2004 is a sign of progress and success, not failure, in our licensed facilities.

Research and experience have proven that creating a health care organizational culture that promotes the reporting of errors by staff, the careful and thorough review of the errors and the processes that cause or contribute to those errors, and the inclusion of staff in the improvements and changes leads to an environment of patient safety improvements.

The Department recognizes that Tennessee has made major improvements in the efforts of patient safety and quality improvement throughout all licensed health care facilities, but also realizes that "patient safety is a never-ending process".

Introduction and Background

The "Health Data Reporting Act of 2002" requires the Department of Health to provide an aggregate report summarizing the type and number of unusual events reported by facilities to the Board for Licensing Health Care Facilities. The law also directs the Department to work with representatives of facilities and other interested parties to develop recommendations to improve the collection and assimilation of specific aggregate health care trends over time and to identify system-wide problems for broader quality improvements. These recommendations are to be issued each year by July 1.

The General Assembly's intent in passing this legislation was to ensure the delivery of the best medical care for the citizens of Tennessee by minimizing the frequency and severity of unexpected events and improving the delivery of health care services through the collection of meaningful health care data.

Tennessee's Unusual Incident Reporting System (UIRS) is an electronic adverse event reporting system implemented in 2001. For the purpose of reporting in UIRS, an occurrence is an unintended adverse and undesirable development of an individual patient's/resident's conditions, such as a patient death or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards. Some occurrences are not related to the patient/resident but are unusual occurrences. All occurrences are investigated internally by the health care facility in order to complete a investigative analysis of the event. All adverse events are not medical errors and should not be considered as such.

In this third report of unusual event reporting, the Department provides information regarding the upgrading of UIRS, as well as analysis of data collected regarding unusual events that occurred during the year 2004. The report also provides information reported through the hospital discharge data, includes information regarding activities undertaken to assure complete reporting by health care facilities, and presents a description of future improvements. Future improvements include ongoing enhancements of the UIRS system, ongoing training and support and continuing in-depth data analysis by occurrence code to improve the quality of care and safety of patients in a health care facility.

Tennessee has a long history of implementing efforts to improve patient safety by mandating health care facilities reporting and initiating improvement actions based on unusual events occurring in the individual facilities. Since the early eighties, Tennessee has required reporting of unusual events. Initially, the incident reporting system was a paper system, which contributed very little to quality improvement in patient safety efforts. Then, in 2001, the State implemented the electronic extranet-based system, utilizing New York's Patient Safety tracking system as a guide in the development of a similar system. In 2003, a user group was established to assist with needed upgrades and continued improvements of UIRS. The electronic reporting system contains all the required security measures to protect the data so facilities can query the database to compare their experience with reported events to the statewide or regional experiences while the identity of individual facilities in the comparative groups is not disclosed. The comparative

database is a useful tool in support of facility quality improvement activities. Additionally, facilities can use the system to create comparative reports in a variety of graphic formats.

The Department believes that before patient safety improvement can be made, there must be an awareness and recognition of adverse events by facilities. Changes in organization culture, the involvement of key leaders, the education of employees, the establishment of patient safety committees, the development and adoption of safe protocols and procedures are just a few of the facility efforts being used to reduce medical errors and improve patient safety. Since the emphasis has been placed on reporting, it is felt that facilities with the highest reporting rates are those that are most keenly aware of occurrences within their facilities and are in the best position to bring about system improvements. The Department oversees facility compliance with reporting responsibilities to ensure the process is fulfilled. The Department also directly investigates all occurrences to assure facilities conduct internal investigative analyses, develop a corrective action plan and develop appropriate measures of effectiveness. A non-punitive approach was taken in 2002 as facilities became familiarized with the new requirements. However, the Department is now citing facilities for failure to report and/or not reporting timely. There were 175 deficiencies cited to facilities for not reporting an event that occurred in their facility in 2004. Approximately 31% of the reports received from facilities did not meet the seven business day requirement as established by the statute.

2004 Progress Report

The Department identified several areas for improvement in its 2003 annual unusual event report. The report stated that before patient safety improvements could be made, there would have to be an awareness and recognition of adverse events by facilities. Changes in organizational culture, the involvement of key leaders, education of employees, establishment of patient safety committees and the development of safe protocols were all areas recognized to target within health care facilities. The Department addressed these areas with four (4) monumental projects; 1) Tennessee's 1st Annual Patient Safety Summit; 2) participation in a year-long grant project related to patient safety; 3) overhauling and implementing enhancements to the electronic unusual event reporting system (UIRS); and 4) implementation of patient safety website accessed through the Department of Health site.

Patient Safety Summit:

The 1st Annual Patient Safety Summit took place on August 26, 2004, at the Loew's Vanderbilt Plaza in Nashville, Tennessee. Original estimates expected approximately 150 attendees. Registration was cut off at over 400 attendees. Nationally recognized speakers including former astronaut Dr. James Bagian, Director of Veterans Administration, National Center for Patient Safety; Dr. Gerald Hickson, Center for Patient Safety and Professional Advocacy, Vanderbilt University School of Medicine; Grena Porter, owner of Principal QRS Healthcare Consulting; and Linda Kenney, President, Medically Inducted Trauma Support Services (MITTS), Mansfield, Massachusetts, provided a full day of the latest information in patient safety. Patient Safety Awards were presented to nominees implementing the best patient safety projects in their facilities during 2004.

Grant Project:

To assist facilities in addressing these issues, the Department was successful in receiving a grant from a joint project of the Veteran's Administration and the Agency on Health Research and Quality (AHRQ). The project, called Patient Safety Improvement Corps (PSIC), allowed two state representatives and two pilot hospitals in Tennessee to work as a team participating in a year long project. The project allowed the team to receive training in patient safety from national leaders as well as requiring each team to select a project to implement in their state. Tennessee chose "Creating a Culture of Safety within the Hospital Setting" and is outlined below:

> **Tennessee Partners**: Cathy Green, RN, Project Leader, Director of Licensure/Health Care Facilities; Pam Hines, RN, East TN Surveyor; Polly Kromhout, Patient Safety and Risk Reduction Coordinator, UT Medical Center; Joe Saarinen, Risk Manager, Patient Safety Officer, Centennial Medical Center.

Training: September 21-28, 2004 Washington, DC.; January 24-27, 2005 San Diego, CA; May 16-20, 2005 Washington, DC (Presentation of team project). Conference calls with other state teams were facilitated by AHRQ every 2 weeks.

Overview: Creating a patient safety culture within their organization is a major concern for healthcare providers in Tennessee. Although the Department experienced a 45% increase in reporting of medical errors/unusual events by hospitals in 2004, the Department realized that there continued to be a problem with under-reporting and a need for improvement of facilities' environment that would support patient safety improvements. Counting and reporting errors does nothing to eliminate the errors themselves. Only the creation of a healthcare organizational culture that promotes the reporting of errors by staff, the careful and thorough review of the errors and the processes that caused or contributed to those errors, and the inclusion of staff in the improvements and changes to the processes will there be any changes in the environment of patient safety within healthcare organizations. It takes a commitment on the part of the organization's leadership to take on the crusade for patient safety. Frontline or "sharp end" staff will only feel safe in coming forward to report errors when they realize that the organizational culture is not about blame, but truly creating an environment of patient safety.

Assumptions:

1. There is a basic fear in reporting- professionals are afraid they will be judged by peers, may be fired or lose their professional license.
2. Professionals and non-professionals are not encouraged to report; organizational culture is lacking support of culture of safety or "blames" individual vs. processes and systems.
3. Staff is unsure of what to report due to lack of education and knowledge of existing interpretative guidelines.
4. It takes time to report—facilities perceive that there are no incentives to reporting unusual events.

Tennessee Partners' Goals:

1. Establish Department policy on what constitutes a "blameworthy event". This will allow healthcare professionals to know exactly when an error would be reported to appropriate professional board for possible disciplinary action. This will alleviate fears of coming forward and possibility of losing professional license. The partnership feels this will be a major improvement to the current culture in Tennessee.
2. Conduct staff surveys on safety climate in their organization using the results to establish baseline data in each hospital.
3. Evaluate number of unusual events reported in 2003 for each hospital as baseline data.
4. All Grant partners will meet with hospital administration to outline project and educate them by providing suggestions on ways to highlight patient safety efforts and use established talking points.
5. Encourage consistent walk-rounds by administration to foster environment of safety.

6. Provide education to staff in each hospital on purpose of reporting, conducting internal investigative analyses, and the culture of patient safety.
7. Provide education to risk management or others responsible for reporting errors to the Department on enhancements made to UIRS system and the benefits of utilizing its comparative reports.

Evaluation of Project:

1. Re-survey staff in April-May 2005 to compare with original baseline survey data to determine if staff realize a change in culture within their organization.
2. Track number of unusual events reported by each hospital to determine if increases have been noted. (This factor alone does not indicate an improved culture of safety.)
3. Track number of professionals referred to Health Related Boards as result of establishing blameworthy criteria.
4. Highlight actions taken by each hospital to change the organizational culture.
5. Share findings with 2nd Annual Patient Safety Conference and Tennessee Hospital Association (THA).
6. Determine if aggregate reporting would assist facilities in tracking and trending some unusual events in a more efficient manner, e.g. falls and other frequently reported events. An evaluation of Corrective Action Plan data will be reviewed to see if basic understanding exists and all components are reviewed with each event.

UIRS Enhancements:

The Department worked with a task force comprised of provider representatives who routinely used the electronic system for reporting unusual events. This task force met over fifteen months to identify and make significant changes to the current electronic Unusual Incident Reporting System (UIRS). UIRS 3.0 was implemented on January 10, 2005, with the following enhancements and revisions:

- **Security Levels**. As with UIRS 2.0, the new system is secured behind a firewall. The server is located behind a second firewall and not accessible from outside the state network. Privacy is protected by use of digital certificates and facilities can only view non-aggregate data on their facility. Each licensed facility was issued a master account. This account allows the facility to create multiple users, if needed. This capability also allows one user to be assigned to multiple facilities within an organization, especially assisting corporate providers with multiple facilities located in Tennessee.
- **Standardization**. This feature will assist with more uniform data being submitted to the Department. The use of drop-down boxes with standardized choices not only assists with consistency, but further expedites data entry and the reporting process for facilities. Drop down boxes were added to required data fields on the initial one page report, corrective action plan and measures of effectiveness. These areas were also enhanced to provide a tutorial while moving through the fields. Examples were added in areas of corrective action plan and measures of effectiveness as a means of further on-site provider education.
- **Expansion of Categories**. Many of the old categories available for selection when identifying the root or basal cause of an unusual event were too broad and responses

were narrowed down in the upgraded system to allow the provider to get closer to the root or basal cause. Example: Human Resources choice on basal cause field was deleted and numerous choices e.g. staffing, supervision, competency have been added.

- **Spellchecker**. A spell-check feature has been added to the initial report narrative section.
- **Alerting Improvements**. The facility main page has a new feature to alert providers about the status of a report and the date the corrective action plan is due.
- **Validation**. The system has been set up to adjust itself in the fields required based on the event reported. Example: If a code in the 100's category (medication error) has been selected, a pop-up page appears for the provider to enter medication error supplement page as a forced function. If a field is not completed, the system will not allow the provider to proceed forward with submitting a report.

Tennessee Improving Patient Safety Website:

With input from the Commissioner's Tennesseans Improving Patient Safety (TIPS) task force, the Department has implemented a patient safety website. This site is comprehensive for both consumers and health care providers offering many links and tools to better equip them in addressing patient safety issues. Several best practices endorsed by TIPS were adopted by Health Related Boards and the Board for Licensing Health Care Facilities in 2004, and have been placed on the site for easy access. In addition, aggregate reports of unusual events occurring in licensed health care facilities are available. These reports can be customized and retrieved by quarter, year, and facility type. The site also has links to national websites and organizations focusing on resources available for patient safety. For example, the second most reported unusual event in Tennessee is "falls with fractures". The Veteran's Administration has developed a Falls Toolkit and made it available for use by any health care facility. The kit may be downloaded from this site. Previous 2004 Patient Safety Award winners and summaries of their initiatives are also on the site. This website is monitored and updated frequently to assure the latest information is available.

Patient Safety Indicators

In response to the increase need to measure patient safety, the Agency for Healthcare Research and Quality (AHRQ) developed a set of Patient Safety Indicators (PSIs), which are specifically designed for screening administrative data for incidences of concern related to patient safety. Although there are reported limitations to the Patient Safety Indicators, states and hospitals continue to use the data sets to benchmark quality improvements.

While these data are relatively inexpensive, convenient to use, and represent a rich data source, the disadvantages should also be considered when evaluating quality of health care. At least three limitations of administrative data warrant caution:

- ***Coding differences*** make "fair" comparisons across hospitals difficult.

- ***Ambiguity about when a condition occurs.*** Most administrative data cannot distinguish whether a specific condition was present at admission or whether it occurred during the stay.

- ***Limitations of ICD-9-CM coding.*** The codes themselves are often not specific enough to adequately characterize a patient's condition, which makes it impossible to perfectly risk adjust any administrative data set, making fair comparisons across hospitals difficult.

Tennessee Hospital Association has worked with their membership to provide hospital specific PSI rate comparison reports that assist hospitals with their internal quality improvement activities. Hospitals then conduct extensive chart reviews to compare the actual clinical findings with the rates and cases identified from the Patient Safety Indicator software. The chart reviews have identified several issues with the use of these data sets. The following are examples of limitations from Tennessee hospitals' clinical chart reviews:

1. Administrative data does not capture end of life or comfort care patients with DNR orders.
2. The administrative data set allows only one source of admission code. Patients admitted from long term care settings via the emergency room will be coded ER as the admit source. Several PSI's exclude transfers and long term care patients in their definitions, yet this information is often not captured in the current administrative data collection, skewing the PSI reports.
3. The presence of a condition (such as decubitus ulcer) on admission as a co-morbid condition versus the development of the condition during care as a complication can not be determined from the administrative data. The clinically audited charts indicated the cases identified in PSI 3 had the condition present at admission.

Patient Safety Indicators and Tennessee Hospitals:

Every patient entering a hospital licensed by the Tennessee Department of Health has high expectations of the quality of care they will receive during their confinement. Each hospital, at the same time, has policies, and procedures in place to guide and monitor the care provided and ensure the safety of the patient while in facility. With almost a million inpatient hospital stays annually, it is unrealistic to expect a totally error-free patient safety record. Conversely, there are preventable problems that possibly can be addressed if identified.

In a non-adversarial relationship, providers and regulators work to reduce or eliminate identified problems. In Tennessee, the Unusual Incident Reporting System (URIS) is one cooperative response. Another is the use of Hospital Discharge Data System (UB-92). Reported by each licensed hospital, this billing information is collected and analyzed by providers and the Tennessee Department of Health. An additional use is as input in generating Patient Safety Indicators.

Patient Safety Indicators are a set of measures providing information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth. The PSIs were developed by the Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services after a comprehensive literature review, analysis of ICD-9-CM codes, review by a clinician panel, implementation of risk adjustment, and empirical analyses. In Appendix V, the twenty patient safety indicators used in this section are defined.

The 2003 information excludes information from three acute care hospitals, one in Davidson County, one in Knox County and one in rural East Tennessee. Edited data for those hospitals were not available. Combined, the three facilities had fewer than 2,000 total discharges during 2003.

Presented in Table 1 is the count of the number of potential problems identified using UB-92 data and the definitions of PSIs for the years 1998 through 2003. Examining the years 2000 and later, upward trends are noted in thirteen of the twenty PSI categories. In particular, the number of “Deaths in Low-Mortality DRGs” increased by 127% while “Postop Respiratory Failure” showed a growth in cases of 44% over the interval. Several categories increased more than 20%.

Over the six years spanned by Table 1, the number of “Infections Due to Medical Care” grew at an annual rate of over ten percent. Persistently increasing, the number of reported infections presents a challenge to the industry. With public attention now sharply focused on this problem area, a reversal of the current trend is required. The slowing of the increase from 2002 to 2003 is a first step. However, the number of incidents reported from 2002 to 2003 still rose in terms of patients affected.

Table 1. Number of Reported Discharges from Tennessee Short-Stay Hospital with a Specific Patient Safety Problem, 1998-2003

AHRQ Hospital-Level Patient Safety Indicators	1998	1999	2000	2001	2002	2003
Complications of Anesthesia	114	120	135	110	142	130
Death in Low Mortality DRGs	306	144	132	157	184	301
Decubitus Ulcer	5,026	4,808	4,921	5,510	5,673	5,981
Failure to Rescue	3,551	3,607	3,820	3,898	3,979	4,091
Foreign Body Left In During Procedure	51	62	58	63	53	65
Iatrogenic Pneumothorax	508	521	482	502	555	499
Infection due to Medical Care	1,098	1,213	1,369	1,508	1,704	1,743
Postoperative Hip Fracture	134	120	130	112	149	104
Postoperative Hemorrhage or Hematoma	352	371	410	390	346	371
Postop Physiologic and Metabolic Derangement	78	73	88	90	119	114
Postop Respiratory Failure	253	315	379	401	491	546
Postop Pulmonary Embolism or Deep Vein Thrombosis	1,722	1,790	1,913	2,122	2,263	2,395
Postoperative Sepsis	366	329	400	400	456	475
Postoperative Wound Dehiscence	128	117	106	118	93	90
Accidental Puncture or Laceration	1,659	1,846	1,920	2,082	2,286	2,240
Transfusion Reaction	3	8	1	7	6	5
Birth Trauma	1,116	946	662	760	520	578
Obstetric Trauma - Vaginal Delivery without Instrument	1,645	1,274	1,157	1,005	1,021	949
Obstetric Trauma - Vaginal Delivery with Instrument	4,814	5,185	5,085	5,165	4,856	5,065
Obstetric Trauma - Cesarean Delivery	141	140	106	116	105	140

Source: Tennessee Department of Health, Office of Policy, Planning and Assessment, Division of Health Statistics.

A rate is simply the ratio of the number of something found in a defined population divided by the defined population. For patient safety indicators, the number of discharges with a particular problem is the numerator. The denominator could be the total number of discharges for a year. The population at risk, though, is probably smaller. Not every patient, for example, is at risk for obstetric trauma

The numerator and denominator for each PSI are defined in Appendix V. Each rate in Table 2 is expressed per 1,000 selected patients. The Tennessee data is based on three-year averages for the years indicated.

Table 2. Number of Patient Safety Incidents per 1,000 Selected Discharges, Tennessee Short-Stay Hospitals 1998-2000, and 2001-2003, and the United States, 2000

	Incidents per 1,000 Selected Patients		
	United States	Tennessee	
AHRQ Hospital-Level Patient Safety Indicators	2000	1998-2000	2001-2003
Complications of Anesthesia	0.6	0.56	0.54
Death in Low Mortality DRGs	2.44	0.99	1.07
Decubitus Ulcer	23.9	21.73	24.05
Failure to Rescue	129.4	153.18	133.75
Foreign Body Left In During Procedure	0.07	0.08	0.08
Iatrogenic Pneumothorax	0.63	0.91	0.86
Infection due to Medical Care	1.5	1.97	2.45
Postoperative Hip Fracture	1.26	1.02	0.90
Postoperative Hemorrhage or Hematoma	1.33	1.95	1.77
Postop Physiologic and Metabolic Derangement	0.78	0.83	0.99
Postop Respiratory Failure	9.3	4.19	5.67
Postop Pulmonary Embolism or Deep Vein Thrombosis	3.47	9.36	10.88
Postoperative Sepsis	11.8	12.39	13.72
Postoperative Wound Dehiscence	1.95	2.54	2.07
Accidental Puncture or Laceration	2.45	2.92	3.27
Transfusion Reaction	0.005	0.006	0.008
Birth Trauma	5.61	11.86	8.20
Obstetric Trauma - Vaginal Delivery without Instrument	218.6	209.56	217.73
Obstetric Trauma - Vaginal Delivery with Instrument	80.8	95.30	96.51
Obstetric Trauma - Cesarean Delivery	5.6	6.69	5.38

As might be expected with twenty indicators, the will be variations across time. For the 1998-2000 period, Tennessee's rates were higher than the US 2000 for 14 of the 20 PSIs. Rate comparisons for the 2001-2003 Tennessee experience vis a vis the US 2000 produced similar results with Tennessee higher in 14 categories but a slightly different set than in 1998-2000. Noteworthy changes from 1998-2000 to 2001-2003, within Tennessee, are the 13 percent decline in the rate of "Failure to Rescue" and the 24 and 11 percent increases in the rates for "Infection Due to Medical Care" and "Postoperative Sepsis" respectively.

Table 3. Rate of Patient Safety Incidences per 1,000 Selected Discharges, Tennessee Short-Stay Hospitals, According to Tennessee Grand Divisions, Three-Year Averages, 1998-2000 and 2001-2003

AHRQ Hospital-Level Patient Safety Indicators	Average 1998-2000			Average 2001-2003		
	East	Middle	West	East	Middle	West
Complications of Anesthesia	0.48	0.86	0.28	0.5	0.7	0.4
Death in Low Mortality DRGs	0.99	0.80	1.11	1.1	0.9	1.2
Decubitus Ulcer	20.38	21.58	23.14	24.5	22.2	25.5
Failure to Rescue	147.40	135.20	177.23	128.2	119.6	155.6
Foreign Body Left In During Procedure	0.09	0.07	0.08	0.1	0.1	0.1
Iatrogenic Pneumothorax	0.80	0.88	1.10	0.9	0.7	1.0
Infection due to Medical Care	1.75	1.56	2.84	2.2	1.8	3.7
Postoperative Hip Fracture	1.20	0.84	0.99	1.0	0.8	0.9
Postoperative Hemorrhage or Hematoma	1.98	1.84	1.88	1.8	1.8	1.7
Postop Physiologic and Metabolic Derangement	0.71	0.58	1.56	0.9	0.8	1.8
Postop Respiratory Failure	4.34	3.56	4.79	6.7	4.5	5.7
Postop Pulmonary Embolism or Deep Vein Thrombosis	9.60	7.60	11.27	11.0	8.7	13.7
Postoperative Sepsis	8.52	8.97	23.52	11.7	10.3	24.3
Postoperative Wound Dehiscence	2.67	1.97	2.79	2.5	1.6	1.9
Accidental Puncture or Laceration	3.18	3.03	2.34	3.6	3.3	2.8
Transfusion Reaction	0.007	0.004	0.005	0.005	0.011	0.008
Birth Trauma	22.04	5.09	6.51	15.7	4.4	3.7
Obstetric Trauma - Vaginal Delivery without Instrument	227.17	212.19	190.54	219.8	197.1	248.7
Obstetric Trauma - Vaginal Delivery with Instrument	104.63	72.62	111.31	105.3	77.9	107.9
Obstetric Trauma - Cesarean Delivery	7.64	5.92	6.56	5.7	4.9	5.5

Note: Highlighted region has the highest rate for the three-year period.

Investigated in Table 3 is the variation of PSI rates across Tennessee Grand Divisions. Two time periods are examined, 1998-2000 and 2001-2003. Within each time period, the Division with the highest rate is highlighted.

East and West Tennessee have the preponderance of highest rates in both periods. East and West with nine each in 1998-2000; East with seven and West with ten in 2001-2003.

The final PSI categorization is by the number of licensed beds. Three groupings are presented: Less than 100 beds, 100-249 beds, and 250 beds or more. The PSI rates for the three year period 2001-2003 are presented in Table 4 below.

Table 4. PSI Incidence Rates, Tennessee Short-Stay Hospitals, 2001-2003, According to Number of Licensed Beds

	Incidents per 1,000 Selected Patients			
		Bed Size		
AHRQ Hospital-Level Patient Safety Indicators	All	Lt 100	100-249	250+
Complications of Anesthesia	0.5	0.5	0.7	0.5
Death in Low Mortality DRGs	1.1	1.5	1.0	1.1
Decubitus Ulcer	24.1	35.5	25.4	22.0
Failure to Rescue	133.8	84.3	125.4	143.1
Foreign Body Left In During Procedure	0.1	0.1	0.1	0.1
Iatrogenic Pneumothorax	0.9	0.4	0.6	1.1
Infection due to Medical Care	2.4	0.6	1.5	3.3
Postoperative Hip Fracture	0.9	1.5	1.2	0.8
Postoperative Hemorrhage or Hematoma	1.8	1.3	1.9	1.8
Postop Physiologic and Metabolic Derangement	1.0	0.6	0.8	1.1
Postop Respiratory Failure	5.7	2.7	5.4	6.0
Postop Pulmonary Embolism or Deep Vein Thrombosis	10.9	7.3	8.5	11.8
Postoperative Sepsis	13.7	11.3	16.4	13.3
Postoperative Wound Dehiscence	2.1	1.1	2.1	2.2
Accidental Puncture or Laceration	3.3	1.5	2.1	4.1
Transfusion Reaction	0.0	0.0	0.0	0.0
Birth Trauma	8.2	9.4	2.9	11.6
Obstetric Trauma - Vaginal Delivery without Instrument	217.8	243.2	182.3	238.0
Obstetric Trauma - Vaginal Delivery with Instrument	96.5	116.2	85.3	102.4
Obstetric Trauma - Cesarean Delivery	5.4	5.4	4.5	6.0

Please note that while rankings can assist in identifying problem areas, in several PSI categories the differences in rates were very small. Additionally, nothing in the analysis presented addresses differences in patient mix either geographically or by, in the case of Table 4, bed size. Nonetheless, shaded cells indicate highest rate of the three bed size categories.

Over the three-year period the ratios of rates for “Infections Due to Medical Care” by bed size was 1:2:5. Using the rate observed in hospitals with fewer than 100 beds as the base, the rate for 100-249 bed hospitals was twice than of smaller facilities , while the rate “250 and up bed” hospitals was 5 times that of the “less than 99 bed” facilities.

Intermediate hospitals, “100-249 beds”, showed a far lower incidence of “Birth Trauma” with rates a third of that for smaller hospitals and a fourth of the rate for larger facilities. The large hospitals had the lowest incidence rates of “Postoperative Hip Fractures” and “Decubitus Ulcer”.

Unusual Incident Reporting System (UIRS) Summary

The Unusual Incident Reporting System (UIRS) has been in production since July of 2001. Data within this summary begins with unusual event reports received as of January 1st 2001 through December 31st 2004.

Table 1: Number of Unusual Incidents Reported, by Facility Type, 2000 – 2004
This table includes totals and percentages for accepted reports on unusual events separated into Facility Type Groups from the year 2000 to 2004. There was a 12.06% increase in the number of reports from 2002 to 2003. There was an additional 15.76% increase in the number of reports from 2003 to 2004. It should be noted that the overall 28% increase in reporting over a two year period primarily indicates an increase in compliance with reporting requirements and not a trend toward decreased patient safety. Hospitals continue to improve their reporting and have increased their rate by over 45% for the second straight year, which now makes up 26.33% of the overall reporting. This rate increase by hospitals is a significant amount over the overall reporting rate increase and is likely due to continued training and understanding about the reporting process. The greatest rate increase was with the "Other" facility types not described here. There were nearly two and a half times the reports by "Other" facility types over last years continuing the significant increase in reporting by "Other" facility types over the last two years. Other facility types include Ambulatory Surgery Centers, Alcohol and Drug Facilities, Home Health Agencies, and Hospice. Nursing Homes showed an increased reporting rate for the second consecutive year in contrast to the reporting rate decrease from 2001 to 2002, however this reporting rate remained close to the same and is significantly less than the overall reporting rate increase. This indicates the continued affect of training in use of the interpretative guidelines has taken hold. The impact of the training is also supported by the continued reduction of Priority 5 reports detailed in Table 5.

Facility Type	Year										% Change 2002 to 2003	% Change 2003 to 2004
	2000		2001		2002		2003*		2004*			
All	6,516	100.00%	4,068	100.00%	3,839	100.00%	4,302	100.00%	4,908	100.00%	12.06%	14.09%
Hospitals	42	0.64%	119	2.93%	616	16.05%	894	20.78%	1,311	26.71%	45.13%	46.64%
Nursing Homes	6,099	93.60%	3,457	84.98%	2,749	71.61%	2,944	68.43%	2,986	60.84%	7.09%	1.43%
Homes for Aged	141	2.16%	53	1.30%	63	1.64%	67	1.56%	64	1.30%	6.35%	-4.48%
Assisted Care Living Facility	127	1.95%	248	6.10%	255	6.64%	315	7.32%	340	6.93%	23.53%	7.94%
Other*	107	1.64%	191	4.70%	156	4.06%	82	1.91%	5	0.10%	97.56%	400.00%

- 2003 and 2004 totals are extracted from the UIRS database. Previous years totals were tallied by manual count in each regional office and combined together for the statewide totals.
- ICF/MRs are now included with "Other" previous years reports separated ICF/MRs out, since they now report to Mental Health it has been removed as a dedicated category.

Additional information regarding the total counts by facility group for 2004 can be found in Appendix VI – Report #1

Table 2: Ranking of Occurrence Codes, Hospitals and Ambulatory Surgical Treatment Centers (ASTCs), 2004
This table ranks the frequency of reported occurrence codes for the entire state across all facility types and specifically identifies Hospitals and ASTCs individually. The Hospital and ASTC columns each show the rank and the count for their reports within these occurrence

codes. It is easily shown that Hospitals and ASTCs share a set of occurrences which happen most frequently. Out of their top thirteen occurrence codes they share twelve. The commonality of the occurrence codes is due to the similarity in the procedures performed at these health care facilities.

Statewide				Hospitals		ASTCs	
Rank	Occurrence Code with Description	Count	%	Rank	Count	Rank	Count
1	901 – Other	1,475	30.05%	3	133	4	13
2	751 - Falls with Fractures	1,228	25.02%	1	239	11	2
3	968 - Physical Abuse	351	7.15%	14	14		
4	808 - Post-Op Wd Infection	256	5.22%	2	227	3	27
5	964 – Altercations	224	4.56%	21	5		
6	970 - Verbal Abuse	190	3.87%	27	4		
7	801 - Repair/Removal of Organ	166	3.38%	4	130	1	36
8	803 - Hemorrhage/Hematoma	151	3.08%	5	121	2	27
9	819 - Unexpected Operation/RTOR	132	2.69%	6	117	5	13
10	915 – Death	89	1.81%	7	63	7	3
11	969 - Sexual Abuse	79	1.61%	24	5		
12	936 - All Other Fires	76	1.55%	15	12		
13	701 – Burns	60	1.22%	13	19	6	3
14	918 - Impairment of Limb	43	0.88%	10	26	12	2
15	972 - Misappropriation of Funds	36	0.73%	36	1		
16	971 - Neglect/Self Neglect	36	0.73%	37	1		
17	933 - Termination of Services	36	0.73%	30	3	16	1
18	913 - Retained Foreign Body	34	0.69%	8	32	15	1
19	806 - Displacement/Breakage of Device	31	0.63%	9	27	8	3
20	303 – Pneumothorax	28	0.57%	11	26	13	2
21	109 - Medication Near Death	26	0.53%	12	22		
22	935 - Facility Fire	25	0.51%	22	5		
23	923 – Elopement	15	0.31%	34	1		
24	922 - Suicide/Attempted Suicide	15	0.31%	26	4		
25	911 - Wrong Patient/Wrong Site Surgery	14	0.29%	17	11	9	3
26	602 - Peripheral Neurological	12	0.24%	16	12		
27	601 - Neurological Deficit	11	0.22%	19	10	14	1
28	108 - Medication Harm	10	0.20%	25	4		
29	301 - Necrosis/Infection	10	0.20%	18	10		
30	932 - External Disaster	9	0.18%	35	1		
31	917 - Loss of Limb or Organ	7	0.14%	20	6		
32	966 – Restraint	6	0.12%	40	1		
33	201 – Aspiration	5	0.10%	31	2	10	2
34	855 - Incorrect Procedure	5	0.10%	23	5		
35	110 - Medication Death	3	0.06%	28	3		
36	963 - Rape of Patient/Staff	3	0.06%	38	1		
37	853 - Ruptured Uterus	3	0.06%	29	3		
38	404 - Wrong Patient/Outdated Blood	2	0.04%	41	1		
39	403 - Wrong Type Blood	2	0.04%	32	2		
41	921 - Death From Crime or Serious Injury	1	0.02%	33	1		
43	854 - Repair Circumcision	1	0.02%	39	1		

Table 3: Ranking of Occurrence Codes, Nursing Homes and Assisted Care Living, 2004
This table ranks the frequency of reported occurrence codes for the entire state across all facility types and specifically identifies Nursing Homes and ACLFs individually. The Hospital and ASTC columns each show the rank and the count for their reports within these occurrence codes. It is easily shown that Nursing Homes and ACLFs share a set of occurrences which occur most frequently. They also correlate directly to the top 5 occurrences statewide with Nursing Homes having the same set of occurrences in the top 5 with the overall state rankings and ACLFs having 4 out of the Top 5. The inversion of Rank 1 and 2 in Nursing Homes compared to the rest of the state is due to the overuse of the 901 occurrence code. Out of their top thirteen occurrence codes they share ten. The commonality of the occurrence codes is due to the similarity in the care given at these types of health care facilities.

Statewide				Nursing Homes*		ACLF	
Rank	Occurrence Code with Description	Count	%	Rank	Count	Rank	Count
1	901 - Other	1,475	30.05%	1	1,182	1	162
2	751 - Falls with Fractures	1,228	25.02%	2	784	2	111
3	968 - Physical Abuse	351	7.15%	3	322	6	9
4	808 - Post-Op Wd Infection	256	5.22%	28	1		
5	964 - Altercations	224	4.56%	4	207	3	10
6	970 - Verbal Abuse	190	3.87%	5	175	7	7
9	819 - Unexpected Operation/RTOR	132	2.69%	22	2		
10	915 - Death	89	1.81%	14	13	8	4
11	969 - Sexual Abuse	79	1.61%	6	65	10	3
12	936 - All Other Fires	76	1.55%	7	53	4	9
13	701 - Burns	60	1.22%	8	34	13	1
14	918 - Impairment of Limb	43	0.88%	13	14	15	1
15	972 - Misappropriation of Funds	36	0.73%	10	25	5	9
16	971 - Neglect/Self Neglect	36	0.73%	9	29	18	1
17	933 - Termination of Services	36	0.73%	11	24	20	1
18	913 - Retained Foreign Body	34	0.69%			19	1
19	806 - Displacement/Breakage of Device	31	0.63%	25	1		
21	109 - Medication Near Death	26	0.53%	20	3	17	1
22	935 - Facility Fire	25	0.51%	12	14	12	2
23	923 - Elopement	15	0.31%	15	10	9	3
24	922 - Suicide/Attempted Suicide	15	0.31%	16	7	11	3
28	108 - Medication Harm	10	0.20%	19	4	16	1
30	932 - External Disaster	9	0.18%	17	6	14	1
31	917 - Loss of Limb or Organ	7	0.14%	26	1		
32	966 - Restraint	6	0.12%	18	5		
33	201 - Aspiration	5	0.10%	24	1		
36	963 - Rape of Patient/Staff	3	0.06%	21	2		
40	962 - Adult Abduction	1	0.02%	23	1		

* Also includes reports from Hospital LTC SNF/NF units.

Additional information regarding the distribution of Occurrence Codes for each facility type group can be found in Appendix VI – Report #1

Table 4: Participation in Reporting by Facility Type, 2004

While the use of the web-based reporting tool has increased participation in reporting, additional work needs to be done as is evident in the table below. While it is true that not all facility types have the same frequency of unusual events and each facility within a group will have a unique occurrence, the numbers clearly show that there is a lack of regular reporting for facility types as a whole. The top two reporters by facility type are Long Term Care Facilities (Nursing Homes) at 95.04% participation and Hospitals at 72.08%. There is still much room for improvement. Approximately 60% of all facilities have never reported any occurrences (*See Appendix VI – Report #2);* of those that do report approximately 32% are turned in late. (*See Appendix VI – Report #3)* There were 175 deficiencies sited in 2004 for late or non-reporting events into UIRS (Home Health – 20, Hospice – 1, Home Medical – 29, LTC – 62, ASTC – 22, ESRD – 12, Hospital – 29).

	2003					2004					
	Total Facilities	Number of Facilities Reporting	Percentage of Facilities Reporting at least once	Number of Facilities Reporting over Web	Percentage of Facilities Reporting at least once over the website	Total Facilities	Number of Facilities Reporting	Percentage of Facilities Reporting at least once	Number of Facilities Reporting over Web	Percentage of Facilities Reporting at least once over the website	Percent change in Overall Reporting
Long Term Care	343	326	95.04%	211	61.52%	337	315	93.47%	240	71.22%	-1.57%
Hospital	154	111	72.08%	87	56.49%	175	111	63.43%	91	52.00%	-8.65%
Assisted Care Living Facility	185	104	56.22%	35	18.92%	188	108	57.45%	43	22.87%	1.23%
Hospice	52	3	5.77%	2	3.85%	55	1	1.82%	1	1.82%	-3.95%
Home Health	156	8	5.13%	4	2.56%	157	9	5.73%	6	3.82%	0.60%
Alcohol & Drug Facility	292	9	3.08%	2	0.68%	295	3	1.02%	1	0.34%	-2.06%
Residential Home for the Aged	148	27	18.24%	10	6.76%	138	38	27.54%	10	7.25%	9.30%
Ambulatory Surgical Treatment Center	139	21	15.11%	9	6.47%	144	43	29.86%	25	17.36%	14.75%
Total	**1469**	**609**	**39.30%**	**360**	**23.26%**	**1489**	**628**	**40.08%**	**417**	**26.65%**	**0.78%**

Table 5: Distribution of Reports Received by Prioritization, 2001 – 2004

The impact of training continues to have an influence on the overall prioritization of unusual events. Priority 5 events (formerly called Category 5) has primarily leveled off with a slight decrease as the awareness of what types of events are reportable begins to take hold in the reporting community. Further significant rate decreases are unlikely as the major impact was felt after the first year of training. The 2002 annual patient safety report indicated a "significant change" in the rate of Priority 1 – 3 events, but in large part this was due to non-assignment of priorities to events in the automated system. Later correction has significantly decreased 2001 Priority 5 data and redistributed those events across the other groups more in line with more recent reporting as seen below. Another significant trend is the increased rate in reporting of Priority 2 events. Priority 2 events as outlined in the administrative guidelines are made up of the occurrence codes 403, 404, 601, 602, 801, 803, 806, 808, 819, 851, 853, 854, 855, 913, 917, and 970 by default. These codes are primarily procedural related and therefore mostly used by hospitals. They increased by a rate of 82% and 76% over the last two years. The approximate 90% increase in reporting by hospitals over the last two years

has had some influence over this increase, but other trends may be at work here as well because the increase rate of Priority 2 events is nearly twice that of the increased hospital reporting. One factor contributing to this upward trend are new federal guidelines related to response times regarding these types of occurrences which has led to their regular classification as priority 2 occurrences.

	2001		2002		2003		2004		Total
Priority 1	**351**	**11.57%**	**740**	**17.07%**	**710**	**15.07%**	**807**	**15.10%**	**2,608**
Priority 2	**45**	**1.48%**	**311**	**7.18%**	**566**	**12.01%**	**994**	**18.60%**	**1,916**
Priority 3	**1,644**	**54.20%**	**1,931**	**44.55%**	**1,693**	**35.94%**	**1,845**	**34.52%**	**7,113**
Priority 4	**581**	**19.16%**	**686**	**15.83%**	**1,333**	**28.30%**	**1,264**	**23.65%**	**3,864**
Priority 5	**150**	**4.95%**	**480**	**11.08%**	**409**	**8.68%**	**435**	**8.14%**	**1,474**
Unrated	**262**	**8.64%**	**186**	**4.29%**	**0**	**0.00%**	**0**	**0.00%**	**448**
Total	**3,033**	**100.00%**	**4,334**	**100.00%**	**4,711**	**100.00%**	**5,345**	**100.00%**	**17,423**

- The above table includes Priority 5 reports due to the fact they are included in the comparison. Typically Priority 5 reports are excluded because they are generally "over reports" and did not meet the criteria of being a reportable unusual event. Unrated reports are no longer possible as an initial prioritization is assigned to every reported event based on occurrence code. Please be aware that grand totals including Priority 5 reports will be higher than those excluding them.

Additional information regarding the distribution of Priorities by Year can be found in Appendix VI – Report #4

Excerpt from Division of Health Care Facilities Administration Policies and Procedures File No. 0225

"Regional Office staff will utilize the categories below to determine timeframes for follow-up investigations. UIRS will automatically assign reported events occurrence codes to the appropriate response category (I-V). Regional Administrative staff shall have the authority to increase or decrease an individual unusual event's assigned category based on documentation received in the facility's report and any subsequent information obtained by staff contacts to the facility requesting additional information."

A "Priority" as it is now called can be rated between 1 and 5. A (1) would indicate death, near death, abuse, neglect and/or misappropriation of funds; a (2) would indicate serious permanent injury and potential to affect others; a (3) would indicate minimal permanent injury, a (4) would indicate minimal injury, and a (5) is an event that did not meet the criteria required to report.

Table 6: Method of Reporting Unusual Incidents by Facilities, 2001 – 2004
Since the inception of the UIRS web-based reporting mechanism, participation in the online reporting method has increased to become the number one method of reporting. The rate of online reporting has increased 50.91% over a four year period and now is the way 70% of the reports are received. Using the standardized web-based reporting increases accuracy, improves efficiency, and reduces the overall processing time. The process has been further refined in the 2005 data collection process when the new release of the UIRS application was released. Next years report will reflect data collected from this updated system.

	2001		2002		2003		2004		Total
Fax	**1,946**	**64.16%**	**2,839**	**65.51%**	**1,827**	**38.78%**	**1,591**	**29.77%**	**8,203**
Mail	**493**	**16.25%**	**74**	**1.71%**	**13**	**0.28%**	**4**	**0.07%**	**584**
Phone	**10**	**0.33%**	**26**	**0.60%**	**2**	**0.04%**	**0**	**0.00%**	**38**
Web	**584**	**19.25%**	**1,395**	**32.19%**	**2,869**	**60.90%**	**3,750**	**70.16%**	**8,598**
Total	**3,033**	**100%**	**4,334**	**100%**	**4,711**	**100%**	**5,345**	**100%**	**17,423**

- This includes Priority 5 as they are significant in measuring the method of reporting. Typically Priority 5 reports are excluded because they are generally "over reports" and did not meet the criteria of being a reportable unusual event.

Additional information regarding the distribution of Reporting Method by Year can be found in Appendix VI – Report #5 and Appendix VI – Report #6

Areas of Improvement

Revision to Code 901

Code 901, which is used by facilities to report all miscellaneous incidents that do not have an assigned occurrence code, is the number one reported event in Tennessee. A brief analysis of falls in Code 901 was conducted in an attempt to identify any possible relationship with Code 751. The Department was able to extract two hundred and eleven (211) events out of the total one thousand four hundred seventy-five (1,475) events reported. These two hundred and eleven (211) events included falls with soft tissue injury, falls not reportable and falls incorrectly coded and/or wrongly coded events. Constraints in the statute prevent establishing any new reportable categories.

The table below outlines the results:

Total of 211 Falls Reported in Code 901 "Other" Category

Resulted in Soft Tissue Injury -	**Not Reportable -**	**Reportable Under Code 751**	**Other:**
Fall required Sutures, Staples, or other additional Treatment Measures	Fracture was result of an underlying disease (osteoporosis, malignancy, etc.)	Fall resulted in fracture or subdural hematoma	Blunt trauma *en utero*, resident to resident abuse, impaired function as result of surgery, CVA, equipment fell on patient, surgical pin protrusion
155	37	11	8

This increase in Code 901 may be attributed to the Department's interpretation that falls which require additional treatment measures or soft tissue injuries must be reported in Code 901. Nonetheless, the Department will continue to analyze this data for any trends or opportunities. Additionally, trends and data will continue to be presented to the Commissioner's TIPS Committee (Tennesseans Improving Patient Safety) for recommendations on developing safe or best practices based on aggregate data specific to Tennessee.

Provider Feedback

The Department continues to develop feedback reports for providers on the data they enter into UIRS 3.0 as well as comparative reports. Reports that have been available to providers have been limited to top ten basal causes and reported events within their facility or within the facility type statewide. Recommendations were made by the UIRS provider task force to develop risk-adjusted reports. For example, reports related to length of stay and bed size of the facility will offer providers better comparative reports that can be used within their own organization to improve quality and prevent recurrence of some unusual events. The ability to track the time of

day a fall occurs would allow a facility to determine what factors may have played a role in the event.

Data Analysis

Analysis of data has been and still is limited within the Department and licensed healthcare facilities. This is related to several factors:

- Lack of resources of both staff and technology
- Having adequately trained and skilled individuals in risk assessment and corrective action planning
- Continuous staff turnover
- Lack of standardized data collection

The upgrades implemented to UIRS 3.0 in 2004 will assist the Department and licensed facilities in consistently analyzing the unusual event data for trends and possible safe practices. The Department recognizes that the capacity to conduct data analyses is uneven across the health care spectrum both in experience and skill level and must put forth efforts to assist in eliminating these barriers. Few facilities have sufficient experience with risk assessment and analysis skills needed to analyze the causes of medical errors. We need to assist facilities with the necessary skills and knowledge to move to a system in which they routinely undertake analyses of the causes of error with a pro-active approach.

Creating a Culture of Patient Safety

Patient Safety is a never-ending process and a culture of safety is critical on two levels to change the traditional response of "name, blame, and shame" which does little to improve safety for the next patient. Health care professionals need to feel safe to honestly acknowledge errors or "near misses" within the institution in which they practice. The licensed facilities also need to feel safe to seek help in identifying and resolving organizational and system-based threats to patient safety without retribution.

Although only two hospitals and two state employees were allowed to participate in the Veterans Administration and Agency for Health Research and Quality Grant Project, this is adequate to move Tennessee along in their efforts of improving patient safety. The team selected as its project the topic of "Creating a Culture of Safety". How appropriate for Tennessee as we have recognized the need to improve our culture of patient safety efforts across the state both within facilities and health care professionals.

CHAPTER NO. 508

SENATE BILL NO. 2316

By Ford

Substituted for: House Bill No. 2259

By Lois DeBerry, John DeBerry, Black, Bowers

AN ACT To amend Tennessee Code Annotated, Title 68, Chapter 11, to require licensed health care facilities to report unusual events and certain other incidents, to ensure certain information related to such reports is retained as confidential information and to enhance the collection and assimilation of relevant health data to assist the development of best practices by health care providers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 68, Chapter 11, Part 2, is amended by adding the following language as a new, appropriately designated section:

Section ____.

(a) This act shall be known as the "Health Data Reporting Act of 2002".

(b) The General Assembly desires to ensure the delivery of the best medical care for the citizens of Tennessee. The collection and assimilation of relevant health data, particularly aggregate health data, can facilitate the development and implementation of best standards practices among health care providers. The early detection of medical errors, and unexpected events, and the identification of measures to improve the delivery of health care and to prevent the re-occurrence of such errors, will also enhance the quality of health care services delivered to Tennesseans. The purpose of this act is to assist health care providers and the Department of Health to work together to collect meaningful health care data so as to minimize the frequency and severity of unexpected events and improve the delivery of health care services.

(c) The following definitions shall apply to this act:

(1) "Patient abuse" includes patient neglect, and means the intentional infliction of pain, injury, or mental anguish, or the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident. Nothing in this act shall be construed as authorizing or requiring the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will;

(2) "Board" means the board for licensing health care facilities;

(3) "Commissioner" is the Commissioner of the Department of Health;

(4) "Department" is the Department of Health;

(5) "Facility" is any facility licensed under Title 68, Chapter 11, Part 2;

(6) "Patient" means a person receiving health care services from a facility, and includes a resident at a nursing home facility;

(7) "Unusual event" is an unexpected occurrence or accident resulting in death, life-threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition. An unusual event also includes an incident resulting in the abuse of a patient.

(d)(1) Every facility shall report unusual events, and certain other defined incidents, to the department. Any such unusual event or other defined incident shall be reported to the department by the facility within seven (7) business days from the facility's identification of the event or incident. If a facility incorrectly reports an event or incident, the facility shall file a notice of correction with the department. An unusual event report form shall be developed by the department, in a format similar to the format utilized by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), and shall be utilized for reporting the event or incident. The event report and the corrective action report reviewed or obtained by the department pursuant to this section and amendments thereto, shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. However, the department must reveal upon request its awareness that a specific event or incident has been reported. The affected patient and the patient's family, as may be appropriate, shall also be notified of the event or incident by the facility. This subsection and this act shall not affect any of the provisions of § 63-6-219, or the protections provided by § 63-6-219.

(2) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life-threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

(A) medication errors;

(B) aspiration in a non-intubated patient related to conscious/moderate sedation;

(C) intravascular catheter related events including necrosis or infection requiring repair, or intravascular catheter related pneumothorax;

(D) volume overload leading to pulmonary edema;

(E) blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;

(F) perioperative or periprocedural related complications that occur within forty-eight (48) hours of the operation or the procedure, including:

(i) procedure which results in any new central neurological deficit, or

(ii) new peripheral neurological deficit with motor weakness;

(G) burns of a second or third degree;

(H) falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;

(I) procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

(i) procedure related injury requiring repair or removal of an organ;

(ii) hemorrhage;

(iii) displacement, migration or breakage of an implant, device, graft or drain;

(iv) post operative wound infection following clean or clean/contaminated case;

(v) any unexpected operation or reoperation related to the primary procedure;

(vi) hysterectomy in a pregnant woman;

(vii) ruptured uterus;

(viii) circumcision;

(ix) incorrect procedure or incorrect treatment that is invasive;

(x) wrong patient/wrong site surgical procedure;

(xi) unintentionally retained foreign body;

(xii) loss of limb, impairment of limb, and the impairment is present at discharge or for at least two (2) weeks after occurrence;

(xiii) criminal acts;

(xiv) suicide or attempted suicide;

(xv) elopement from the facility;

(xvi) infant abduction, or infant discharged to the wrong family;

(xvii) adult abduction;

(xviii) rape;

(xix) patient altercation;

(xx) patient abuse or misappropriation of funds;

(xxi) restraint related incidents; or

(xxii) poisoning occurring within the facility.

(3) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported by the facility to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:

(A) strike by the staff at the facility;

(B) external disaster impacting the facility;

(C) disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and

(D) fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.

(4) If health services are delivered in a home setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.

(5) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event or incident reported to the department. The corrective action report shall either: (1) explain why a corrective action plan is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or

incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(6) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the commissioner or the commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action plan shall be made by the board after a contested case hearing.

(7) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section and this act does not change or affect the privilege and confidentiality provided by § 63-6-219.

(8) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in subdivisions (1) and (2). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.

(9) This act does not preclude the department from using information obtained under this act in a disciplinary action commenced against a facility, or from taking disciplinary action against a facility. Nor does this act preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual incident, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to § 68-11-207.

(10) Nothing in this act precludes the department from using the information obtained to develop "best practices" and other criteria to assist facilities in improving the delivery of health care services.

(e) The department shall provide educational information designed to assist facilities in complying with this act and to assist facilities in implementing procedures designed to prevent medical errors.

(f) During the second quarter of each year, the department shall provide the board an aggregate report summarizing by type the number of unusual events and other reportable specific incidents reported by facilities to the department for the preceding calendar year.

(g) The department shall work with representatives of facilities subject to this act, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The department shall prepare and issue a report regarding such recommendations by July 1, 2003.

(h) Nothing in this section shall be construed to eliminate or alter in any manner the required reporting of abuse, neglect, or exploitation of children or adults, or any other provisions of Title 37, Chapter 1, Parts 4 and 6, and Title 71, Chapter 6, Part 1.

SECTION 2. Tennessee Code Annotated, Section 68-11-804(c)(23) is amended by deleting the language "a copy of the incident report and the investigative report shall be forwarded to the department within five (5) days of the incident. The original report of the incident and the investigative report shall be retained by the nursing home" and by substituting instead the language "reported pursuant to Section 1 of this act."

SECTION 3. This act shall take effect upon becoming a law, the public welfare requiring it.

PASSED: March 14, 2002

JOHN S. WILDER
SPEAKER OF THE SENATE

JIMMY NAIFEH, *SPEAKER*
HOUSE OF REPRESENTATIVES

APPROVED this 19th day of March 2002

DON SUNDQUIST, GOVERNOR

INTERPRETIVE GUIDELINES FOR REPORTING UNUSUAL EVENTS

Revised January 2005

TABLE OF CONTENTS

INTRODUCTION

The purpose of this manual is to offer clarification and guidance in specific reporting categories. It provides additional detail to the includes/excludes list. This section contains the intent of the occurrence codes, definitions, notes and examples. It will also give direction on specific coding policy.

General Information

- Definition of Unusual Event:

  "Unusual event" is an unexpected occurrence or accident resulting in death, life-threatening or serious injury to a patient that is not related to a natural course of the patient's illness or underlying condition. An unusual event also includes an incident resulting in the abuse of a patient.

  The Department uses the following definitions as a guide for determining what needs to be reported:

  - "Serious injury", "life threatening", "or harm" requires the patient to undergo significant additional diagnostic or treatment measures.

  - Please refer to the examples for guidance in deciding which incidents are reportable to the Department.

- When you identify more than 2 occurrence codes per event (codes in the 100-800 series) select the two that had the most significant impact on the patient. If you wish to provide additional detail, provide it in the narrative.

- If more than one detail code (codes in the 900 series) applies, select the one that describes the most severe outcome.

- Any repetitive occurrence must be reported as separate submissions (e.g., if a patient is returned to surgery more than once related to the primary procedure, a submission for each return is required).

- Codes that will automatically trigger a visit from the Department.

  Any unusual event associated with a complaint.

  All deaths of reportable unusual incidents

SECTION A

SUMMARY OF INCLUDES/EXCLUDES LIST

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Medication Errors: **Topical, Injectables, IV, PO** **Treatment Medications, Contrasts, Chemotherapy**	108. 109. 110.	A medication error occurred that resulted in permanent patient harm. A medication error occurred that resulted in a near-death event (e.g., an aphylaxis, cardiac arrest). A medication error occurred that resulted in a patient death.	108-110. Any adverse drug reaction that was not the result of a medication error. An allergic reaction in a case where patient did not know of allergy prior to administration of the pharmaceutical agent.
Aspiration	201.	Aspiration pneumonitis/pneumonia in a non-intubated patient related to conscious sedation.	201. Patients intubated on ventilation, or with known history of chronic aspiration.
Intravascular Catheter Related	301. 302. 303.	Necrosis or infection requiring repair (incision and drainage (I&D), debridement, or other surgical intervention), regardless of the location for the repair (e.g., at the bedside, in a treatment room, in the OR). Volume overload leading to pulmonary edema. Pnuemothorax, regardless of size or treatment (including pneumothoraces resulting from a procedure performed through an intravascular catheter, e.g., temporary pacemaker insertion).	301. Any infiltration or infection treated exclusively with cold or warm packs, wound irrigation, IV change, and/or medication use (e.g., IV, PO, topical), AV fistula revisions (renal dialysis). 302. Pulmonary edema clearly secondary to acute myocardial infarction. Pulmonary edema occurring in patients with previously known, predisposing conditions such as CHF, cardiac disease, renal failure, renal insufficiency or hemodynamic instability in critically ill patients. 303. Non-intravascular catheter related pneumothoraces such as those resulting from lung biopsy, thoracentesis, permanent pacemaker insertion, etc.

Blood Transfusion Reactions	403. 404.	Blood transfusion reactions related to wrong type of blood. Blood transfusion related to outdated blood, wrong patient.	
Perioperative/ Periprocedural Related • **within 48 hours**	600s category 601.	Any new central neurological deficit (e.g., TIA, stroke, hypoxic/anoxic encephalopathy).	ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.) 601. Central neurological deficits due to direct procedures on the central nervous system (e.g., tumor dissection or removal, Transient metabolic encephalopathy, ASA 4 and 5, and previously documented potential high risk outcome).
	602.	Any new peripheral neurological deficit (e.g., palsy, paresis) with motor weakness.	602. Deficits due to operative or other procedure on a specific nerve (e.g., procedures involving neuorfibroma, acoustic neuroma, Sensory symptoms or deficits without motor weakness, numbness or tingling, alone, ASA 4 and 5, previously documented potential high risk outcome). NOTE: Deficits due to central neurological insults (such as hemiparesis) are submitted as a 601.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Burns	701.	2nd and/or 3rd degree burns	1st degree burns. Sunburns of 1st and 2nd degree of cognitively alert and physically capable patients.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Falls	751.	Falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma (e.g., hepatic or splenic injury).	Falls resulting in soft tissue injuries. Fractures resulting from prior pertinent pathological conditions.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions**	800s category		Non-serious injuries of known or unknown origin such as laceration, skin tears, or bruising. NOTE: Consider the 911-963 codes, when applicable.
	801.	Procedure related injury requiring repair or removal of an organ. **Any** procedural injury to liver or spleen, including injury associated with lysis of adhesions or manipulation of the organ.	801. Procedure related injuries which do not penetrate, perforate or enter a lumen, require only a suture(s) to serosal/muscular layers to repair, or which do not require removal of an organ. Procedure related injuries resulting from intended, direct operation on an organ or other anatomical structure based on disease process or lack of an alternative approach available to address the presenting surgical condition.
	803.	Hemorrhage or hematoma requiring drainage, evacuation or other procedural intervention or results in serious injury or death.	803. Expected non-symptomatic blood loss related to the procedures • post = cardio pulmonary by-pass blood deperasis • related to disease process
	806.	Displacement, migration or breakage of an implant, device, graft, or drain, whether repaired, intentionally left in place or removed.	806. Occurrences reported in 913 (retained foreign body) or occurrences due to equipment malfunction or defective product reported in 937 or 938.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
	808.	Post-op wound infection following clean or clean/contaminated case. ASA class is required to be noted.	808. Contaminated or dirty case procedure.
	819.	Any unexpected operation or reoperation (RTOR) related to the primary procedure, regardless of setting of primary procedure. (If occurrence involves 801 or 803-808, enter 801 or 803-808 in the 1st occurrence code field, followed by 819 in the 2nd occurrence code field.)	819. Non-anesthesia procedural interventions (e.g., ERCP) usually performed in special procedure rooms in larger hospitals but which are performed in the OR in a smaller hospital simply due to lack of specialized facilities. Procedures that are commonly sequential or repeated (skin flaps, colostomy closure, 2nd look trauma, biopsy follow-up, documented planned 2nd look for ischemia after bowel resection or whenever intestinal ischemia is expected. Also lap 2nd look post oncologic procedure when post-op adjuvant therapy was given (ovarian cancer, Hodgkin's' and non-Hodgkin's lymphoma). Excludes debridement, vascular cases where conservative approach tried first (thrombectomy, fem-pop bypass) but ultimately fails (BKA done as last resort).
	851.	Hysterectomy in a pregnant woman	
	853.	Ruptured uterus	
	854.	Circumcision requiring repair	

	855.	Incorrect procedure or incorrect treatment that is invasive.	855. Venipuncture for phlebotomy, diagnostic tests without contrast agents.

Other Serious Events	900's category		915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission).
	901.	All other unusual incidents or accidents warranting DOH notification, not covered by codes.	
	911.	Wrong Patient, Wrong Site-Surgical Procedure	
	913.	Unintentionally retained foreign body due to inaccurate surgical count or break in procedural technique (sponges, lap pads, instruments, guidewires from central line insertion, cut intravascular cannulas, needles, etc.)	913. Foreign bodies retained due to equipment malfunction or defective product (report under 937 or 938) or those reported under 806.
	915.	Death (e.g., brain death). <u>Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in:</u>	915-919. <u>Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission including cardiac diseases and Dementia DX.</u> Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938.
	917.	Loss of limb or organ.	

Other Serious Events	918.	Impairment of limb (limb unable to function at same level prior to occurrence) and impairment present at discharge or for at least 2 weeks after occurrence if patient is not discharged.	918.	Limb functions at the same level as prior to the occurrence, impairment resolves by discharge or within two weeks if not discharged. Excludes positioning parathesias.
	921.	Crime resulting in death or serious injury to a patient, as defined in 915-919.		
	922.	Suicides and attempted suicides with serious injury as defined in 915-919.		
	923.	Elopement from the facility resulting in death or serious injury as defined in 915-919.	923.	Cases in which the patient outcome would have been the same whether or not the elopement occurred (cancer death, etc.)
	931.	Strike by facility staff.		
	932.	External disaster outside the control of the facility which affects facility operations.	932.	Situations that are related to termination of service should be reported under 933.
	933.	Termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.		
	934.	Poisoning occurring within the facility (water, air, food or ingestion).		

Other Serious Events	935.	Facility fire disrupting patient care or causing harm to patients or staff.	
	936.	All other fires.	
	961.	Infant Abduction.	
	962.	Adult Abduction.	
	963.	Rape by another patient or staff.	
	964.	Resident to resident altercations (nursing homes, homes for the aged, ACLF, A&D facilities would only report those requiring physician interventions).	964. Resident/Patient to Resident/Patient with non-physician interventions and appropriate facility intervention
	966.	Restraint related incident.	
	967.	Infant discharged to wrong family.	
	968.	Physical Abuse.	
	969.	Sexual Abuse.	
	970.	Verbal Abuse.	
	971.	Neglect or Self-Neglect.	
	972.	Misappropriation of Funds.	

SECTION B

FORMS

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
425 FIFTH AVENUE NORTH, CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37247-0508
TELEPHONE (615) 741-7221
FAX (615) 253-4356

UNUSUAL EVENT REPORT

Facility Name: _____ License No: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Fax: _____

π Not Patient Specific **Date of Occurrence:** _____ **Time:** _____ ___ **AM** ___ **PM**

Patient Information: Age: _____ □ Days □ Weeks □ Months □ Years

Race: □ 1 - American Indian or Alaska Native □ 2 – Asian □ 3 – Black or African-American □ 4 – Hispanic or Latino □ 5 - Native Hawaiian or Pacific Islander □ 6 – White □ UK – Unknown

MR # _____ **Sex:** □ Male □ Female

Occurrence Code: _____ _____ _____

Diagnosis: (max. number 4)
_____ Alzheimer/Dementia
_____ Cerebral Vascular Injury/Disease
_____ Diabetes
_____ Gastrointestinal Disorders
_____ Genitourinary Disorders
_____ Heart Disease
_____ Hypertension
_____ Infectious Disease
_____ Malignant Neoplasm/Blood Disorders
_____ Neurological
_____ Neurotic/Personality Disorders
_____ Orthopedic Injury/Condition
_____ Parkinson's Disease
_____ Renal Failure
_____ Respiratory Illness
_____ Vascular Diseases
_____ Other

Procedure: (max. number 4)
_____ Cardiovascular
_____ Cosmetic
_____ EENT
_____ Gastroenterology
_____ Neurologic
_____ OB/GYN
_____ Oncology
_____ Orthopedic
_____ Respiratory
_____ Urology

Brief Summary of Incident: _____

Report Date: _____ Reporter: _____

TENNESSEE DEPARTMENT OF HEALTH
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425 FIFTH AVENUE NORTH, CORDELL HULL BUILDING
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TELEPHONE (615) 741-7221
FAX (615) 741-7051

Medication Occurrence
Unusual Event Supplement
Facility Document

Type of Occurrence *Check All That Apply*	**Where in the process did the error occur?** *Check All That Apply*
☐ Wrong Patient ☐ Wrong Drug ☐ Wrong Dose ☐ Wrong Route ☐ Wrong Frequency ☐ Wrong Time ☐ Omission ☐ Administration After Order Discont'd/Expired ☐ Wrong Diluent/Concentration/Dosage Form ☐ Monitoring Error ☐ Other	☐ Prescribing -- Written order -- Verbal order ☐ Transcription onto: -- Medication Administration Record -- Other Documentation ☐ Dispensing -- Delay -- Error -- Not Available ☐ Administration Process ☐ Documentation On Med Administration Record

Medication Regimen

Generic Name of Medication Given:	**Dose Given:**	**Route Medication Administered:**	**Frequency Given:**
Generic Name of Medication Prescribed to be Given:	**Prescribed Dose:**	**Prescribed Route:**	**Frequency Prescribed:**

Categories of all Staff Involved in the Occurrence (*check all that apply)*

☐ LPN ☐ RN ☐ PA ☐ Pharmacist ☐ Respiratory Therapist
☐ MD Resident ☐ Attending MD ☐ NP ☐ Unit Secretary
☐ Student (specify type) _____ ☐ Other Staff (specify type) _____

Discovery Date/Time:

How was the occurrence discovered?

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
425 FIFTH AVENUE NORTH, CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37247-0508
TELEPHONE (615) 741-7221
FAX (615) 741-7051

Framework for An Analysis In Response to an Unusual event

INSTRUCTIONS

For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, title of responsible person for implementation and associated measure of effectiveness. If, after consideration of such a finding, a decision is made not to implement as associated strategy, indicate the rationale for not taking action.

Assure that the selected measure will provide data to assess effectiveness of the action.

Consider pilot testing of a planned improvement.

Improvement to reduce risk should be implemented in all areas where applicable, not just where the event occurred. Identify where the improvement will be implemented.

Root Cause Analysis	**Narrative Description**				**Action Plan**			
What happened? Adverse Occurrence What are the details of the event? (Brief description) Include date, day of week, time and the area/service involved.	(Write statement on attachment.)							
Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, including Root Cause(s)** Consider each aspect for analysis Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES** **NO**			**Risk Reduction Strategies** Implemented **YES** **DATE**			**Measures of Effectiveness**
Policy or Process (System) in which the event occurred.	The system in place related to the event is effective.				Action:			Measure:
	The system in place related to the event was carried out as intended.							
	An effective policy is in writing.							
	The policy was effectively communicated.							
	An effective procedure is in place.							

Framework for Root Cause Analysis and Action Plan In Response to an Unusual event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies.			**Risk Reduction Strategies**	Implemented		Measures of Effectiveness
		YES	**NO**			**YES**	**DATE**	
Human Resources. (factors & issues)	Staff are properly qualified.				Action:			Measure:
	Staff are currently assessed as competent to carry out their responsibilities.							
	Staffing level plans were in place.							
	Staffing level plans were appropriate.							
	Staff level plans were implemented.							
	Staff performance in the relevant processes is evaluated.							
	Orientation & in-service training are in place							
	Human error did not contribute to the outcome.							
Environment of Care. (including equipment & other related factors)	The physical environment was appropriate for the processes/treatments being carried out.							
	A system is in place to identify environmental at risk.							
	Emergency and failure-mode responses have been planned.							
	Emergency and failure-mode responses have been tested.							
	Controllable equipment factors did not contribute to the event.							
	Controllable environmental factors did not contribute to the event.							
	Uncontrollable external factors, (natural disaster, power outages, etc.) were not a factor in this case.							

Framework for Root Cause Analysis and Action Plan In Response to an Unusual event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES** **NO**			**Risk Reduction Strategies**	Implemented **YES**	**DATE**	Measures of Effectiveness
Environment of Care (Continued)	An emergency preparedness plan is in place.							
Information Management & Communication Issues	Necessary information was available.							
	Necessary information was accurate.							
	Necessary information was complete.							
	Necessary information was clear and unambiguous.							
	Communication among participants was effective.							
	No barriers to communication were identified.							
Standard of Care	The quality of care and services met generally accepted community standards.							
Leadership: Corporate culture	Leadership is involved in the evaluation of adverse patient care occurrences,.							
Other	Note other factors that influenced or contributed to this outcome? Note other areas of service impacted.							

Results of literature review (include key citation(s)):

Executive Summary of the Analysis (note critical findings):

- List titles of Root Cause Analysis participants i.e., Director of Nursing

SECTION C

INTERPRETIVE GUIDELINES
&
DEFINITIONS MANUAL

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Medication Errors: **Topical, Injectables, IV, PO** **Treatment Medications, Contrasts, Chemotherapy**	108. 109. 110.	A medication error occurred that resulted in permanent patient harm. A medication error occurred that resulted in a near-death event (e.g., anaphylaxis, cardiac arrest). A medication error occurred that resulted in a patient death.	108-110. Any adverse drug reaction that was not the result of a medication error. An allergic reaction in a case where patient did not know of allergy prior to administration of the pharmaceutical agent.

INTENT:

- Whenever code 108, 109, or 110 is reported a detail code in the 900 series may also be submitted.

DEFINITIONS:

Medication Error	A medication error is any preventable event that may cause or lead to inappropriate medication use and patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems including prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use. (National Coordinating Council for Medication Error Report and Prevention 1998)
Omission	The failure to administer an ordered dose.
Wrong Time	Administration of medication outside a predefined time interval (established by each institution) from its scheduled administration time (e.g., later or early dose) if error causes patient discomfort or jeopardizes patient's health and safety as stated in long term care guidelines.
Administration after order discontinued/expired	Administration of a medication no longer authorized by the prescriber.
Wrong dose	Administration of a dose other than that prescribed by the prescriber.
Wrong route	Administration by a route other than that prescribed.
Wrong diluent/concentration dosage form	Drug incorrectly formulated or manipulated before and/or after administration OR inappropriate procedure or technique in administration of the drug.
Monitoring error	Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of response to prescribed therapy.
Wrong Patient	Administration of a medication to a patient other than the one for whom it was prescribed.
Wrong drug	Administration of a medication not prescribed for that patient.
Wrong frequency	Administration of a medication at a frequency not prescribed.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Aspiration	201.	Aspiration pneumonitis/pneumonia in a non-intubated patient related to conscious sedation.	201. Patients intubated on ventilation, or with known history of chronic aspiration.

DEFINITION:

Aspiration: New infiltrates on chest x-ray and/or reductions of 10% or more in p02 or 02 saturation (compared to baseline, which should have been recorded as part of the conscious sedation monitoring process) or requiring new oxygen therapy or mechanical ventilation (in those cases where baseline values were not recorded).

NOTE:

Aspiration will be limited to those occurrences related to conscious sedation.

Definition of conscious sedation:

conscious sedation[1] – a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or nonpharmacological method or a combination thereof. In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Futher, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

combination inhalation-enternal conscious sedation (combined conscious sedation) – conscious sedation using inhalation and enteral agents.

When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of combination inhalation-enteral conscious sedation does not apply.

Nitrous oxide/oxygen when used in combination with sedative agents may produce anxiolysis, conscious or deep sedation or general anesthesia.

deep sedation – an induced state of depressed consciousness accompanied by partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or to respond purposefully to physical stimulation *or* verbal command, and is produced by a pharmacological or non-pharmacological method or a combination thereof.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Intravascular Catheter Related	301.	Necrosis or infection requiring repair (incision and drainage (I&D), debridement, or other surgical intervention), regardless of the location for the repair (e.g., at the bedside, in a treatment room, in the OR).	301. Any infiltration or infection treated exclusively with cold or warm packs, wound irrigation, IV change, and/or medication use (e.g., IV, PO, topical). AV fistula revisions (renal dialysis).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Intravascular Catheter Related	302.	Volume overload leading to pulmonary edema.	302. Pulmonary edema clearly secondary to acute myocardial infarction. Pulmonary edema occurring in patients with previously known, predisposing conditions such as CHF, cardiac disease, renal failure, renal insufficiency or hemodynamic instability in critically ill patients.

INTENT:

- To capture iatrogenic volume overloads in patients who are not predisposed to pulmonary edema. The intent is not to capture patients who are at high risk for pulmonary edema due to previously known, predisposing conditions. Predisposing conditions may include but are not limited to: CHF, cardiac disease, renal insufficiency, renal failure, or hemodynamic instability in critically ill patients.

NOTES:

- Pulmonary edema may be diagnosed radiologically, or clinically (based on S&S).

EXAMPLES:

Include:

- Pulmonary edema occurs intra- or post-operatively in a patients with no predisposing conditions, etiology is unclear, volume overload is possible factor.

Exclude:

- Elderly patient with history of CHF, COPD, CAD, etc., admitted with fracture of humeral head and neck, receives IV fluids at 100cc/hr, requires transfer to ICU for acute pulmonary edema likely due to volume overload.
- Patient develops right-sided CHF from volume overload and the CHF does not progress to pulmonary edema.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Intravascular Catheter Related	303.	Pneumothorax, regardless of size or treatment (including pneumothoraces resulting from a procedure performed through an intravascular catheter, e.g., temporary pacemaker insertion).	303. Non-intravascular catheter related pneumothoraces such as those resulting from lung biopsy, thoracentesis, permanent pacemaker insertion, etc.

NOTE:

- Enter the procedure code (Proc) corresponding to the type of intravascular catheter inserted (e.g., Swan Ganz catheter insertion) or the procedure directly involving the use/insertion of the intravascular catheter (e.g., temporary pacemaker insertion procedure).

INTRAVASCULAR CATHETER CODES:

- 37.71 Initial Insertion of Transvenous Lead (Electrode) into Ventricle
- 37.72 Initial Insertion of Transvenous Leads (Electrodes) into Atrium and Ventricle
- 37.73 Initial Insertion of Transvenous Lead (Electrode) into Atrium
- 38.91 Arterial Catheterization
- 38.92 Umbilical Vein Catheterization
- 38.93 Central Venous Catheter (e.g., triple lumen, Hickman)
- 38.94 Venous Cutdown
- 86.06 Insertion of Infusion Pump
- 86.07 Insertion of Totally Implantable Vascular Access Device
- 89.64 Swan Ganz (to monitor pulmonary distal branch pressure)
- 89.68 Monitoring of Cardiac Output

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES	
Blood Transfusion Reactions	403. 404.	Blood transfusion reactions related to wrong type of blood. Blood transfusion reactions related to outdated blood, wrong patient.	403-404	Blood transfusion reactions related to fever and chills. Minor reactions controlled with medication or palliative therapy.

NOTE:

Consider the 900 category codes in addition to the 400 category code when applicable.

Excludes:

Minor reactions controlled with minimum amounts of medication or blood transfusion where reactions are controlled with minimum amounts of medication or palliative therapy.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Perioperative/ Periprocedural Related • **within 48 hours**	600s category		ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.) 601 – 602 Multiple trauma, AAA rapture known at time of surgery, ASA category 4 and 5.

INTRODUCTION TO THE 600S CATEGORY

INTENT:

- To capture any perioperative and periprocedural occurrences occurring in any setting which falls under the control or provider number of the facility (e.g., off-site facility such as an outpatient clinic, lab, or ASTCs).

NOTE:

- The perioperative/periprocedural timeframes begins with either the induction of anesthesia (regardless of type) or, when no anesthesia is involved, the initiation of the procedure, and ends 48 hours later.
- Consider the 900 category codes in addition to the 600 category code, when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Perioperative/ Periprocedural Related • **within 48 hours**			ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.)
	601.	Any new central neurological deficit (e.g., TIA, stroke, hypoxic/anoxic encephalopathy).	601. Central neurological deficits due to direct procedures on the central nervous system (e.g., tumor dissection or removal). Transient metabolic encephalopathy.

INTENT:

- To capture central nervous system (CNS) deficits that are unexpected in relation to the type of procedure performed. It is NOT intended to capture occurrences involving postoperative confusion, disorientation, hallucination, etc., due to transient metabolic encephalopathy from effects of medications, anesthesia, electrolyte disturbance, etc.

NOTE:

- Consider code 919 in addition to code 601 if deficit persists for 2 weeks or is present at time of discharge.

EXAMPLES:

Include:

- Elderly patient exhibits transient postoperative aphasia, hemiparesis (TIA).
- ESRD patient suffers a stroke during dialysis treatment.

Excludes:

- Elderly patient exhibits transient postoperative confusion due to hyponatremia.
- ESRD patient suffers a stroke following completion of dialysis treatment and has left the dialysis area.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Perioperative/ Periprocedural Related • **within 48 hours**			ESRD (End Stage Renal Disease) patients post dialysis treatment. (Include only if occurs while patient is in dialysis area.)
	602.	Any new peripheral neurological deficit (e.g., palsy, paresis) with motor weakness.	602. Deficits due to operative or other procedure on a specific nerve (e.g., procedures involving neurofibroma, acoustic neuroma). Sensory symptoms or deficits without motor weakness (e.g., numbness or tingling, alone). NOTE: Deficits due to central neurological insults (such as hemiparesis) are submitted as a 601.

INTENT:

- To capture injuries (e.g., due to pressure, stretching, positioning, laceration, hematoma, ischemia) to peripheral nerves related to procedures not directly performed on the affected nerve. The intent is NOT to capture peripheral neurological deficits that result from procedures performed directly on the affected nerve.

NOTE:

- Cranial nerves are included in the peripheral nerve category.
- Deficits due to central neurological insults (such as hemiparesis) are submitted as a 601, not as 602.
- Consider code 918 in addition to code 602 if deficit persists for 2 weeks or is present at time of discharge.

EXAMPLES:

Include:

- Footdrop following an orthopedic procedure.

Exclude:

- Facial nerve deficit following surgery for an acoustic neuroma.
- Left-sided hemiparesis in connection with a postoperative stroke following a fractured hip repair (the stroke is submitted as a 601).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Burns	701.	2nd and/or 3rd degree burns	1st degree burns. Sunburns of 1st and 2nd degree of cognitively alert and physically capable patients.

INTENT:

- To capture all 2nd or 3rd degree burns occurring during inpatient or outpatient service encounters.

NOTE:

- A burn is any injury to the tissues of the body caused by heat, chemicals, electricity, radiation or gases.
    - 1st degree burn – tissue injury that is generally characterized by redness and warmth.
    - 2nd degree burn – tissue injury that is generally characterized by reddened skin with blisters and/or superficial, open, weeping lesions.
    - 3rd degree burn – tissue injury that is generally characterized by stiff, ischemic or necrotic tissue which is black or white in color, depending on the etiology of the burn.
- Consider the 915-938 codes in addition to code 701, when applicable.

EXAMPLES:

Exclude:

- Burn present on admission.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Falls	751.	Falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma (e.g., hepatic or splenic injury).	Falls resulting in soft tissue injuries. Fracture resulting from prior pertinent pathological conditions.

NOTE:

- Consider the 915-919 codes in addition to code 751, when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions.**	800s category		NOTE: Consider the 911-963 codes, when applicable. Non-serious injuries of known or unknown origin such as laceration, skin tears, or bruising.

INTENT:

- To capture procedure-related occurrences occurring in any setting which falls under the control or provider number of the facility.

NOTE:

- Procedures to be reported include but are NOT LIMITED to the following:
    - Urinary catheter insertion
    - Central line insertion
    - Endoscopic procedures
    - Operative procedures (including obstetrical-related)
    - Invasive radiological procedures
    - Intubation
    - Dialysis
    - Circumcision
    - Vaginal delivery
- Obstetrical occurrences involving the mother are captured in the 801-819 category code range, whenever applicable. Additional specific mother-related obstetrical occurrences are identified in 851-853 category code range.
- Birth-related occurrences involving the fetus/neonate/newborn that are **not required** to be reported:
    - Neonatal deaths associated with congenital anomalies,
    - Congenital anomalies,
    - Newborn lacerations occurring at the time of delivery,
    - Low Apgar scores,
    - Low Apgar scores and meconium aspiration,
    - Low Apgar scores and seizures,
    - Seizure activity,
    - Transfer of a neonate to another hospital for a higher level of care,
    - Multiple complications in high risk pregnancy, and
    - Stillborn. (see 900 codes)

- Birth related occurrences involving the fetus/neonate//newborn that **<u>are required</u>** to be reported:

  - Newborn fractures occurring at the time delivery
  - Shoulder dystocia and resulting palsy (brachial plexus or Erb's)

- Whenever a 801 or 803 occurrence involves an unexpected operation or return to OR (RTOR) (819) following completion of the original procedure regardless of setting, in the following manner:

  1) enter 801, 803, or 808 in the 1st **occurrence code field**

  2) enter 819 in the 2nd **occurrence code field**

- Whenever an unexpected operation or RTOR (819) is not associated with an occurrence in the 801-808 range, enter the 819 in the first occurrence field and include an explanation in the narrative of the cause for the return or a detail code in the 900 range.

- The purpose for the order in which the codes are entered is important for data analysis. To analyze unexpected operations or reoperations: one query for the 819 code alone in the 1st occurrence code field, and a second query for those occurrence codes 801 and 803-808 in the 1st occurrence code field which also have the 819 code in the 2nd occurrence code field.

- Consider the 900 category codes in addition to the 800 category codes when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions.**	801.	Procedure related injury requiring repair or removal of an organ. **Any** procedural injury to liver or spleen, including injury associated with lysis of adhesions or manipulation of the organ.	NOTE: Consider the 911-963 codes, when applicable. 801. Procedure related injuries which do not penetrate, perforate or enter a lumen, require only a suture(s) to serosal/muscular layers to repair, or which do not require removal of an organ. Procedure related injuries resulting from intended, direct operation on an organ or other anatomical structure based on disease process or lack of an alternative approach available to address the presenting surgical condition.

NOTE:

- Bleeding that is not attributable to a specific intraoperative injury is submitted as an 803. Injuries that occur during laparoscopic procedure and result in unplanned conversion to open procedure.

- **Intraoperative or intraprocedural injuries** include any cut, laceration, tear or nick to an organ or other anatomical structure (e.g., duct, major blood vessel, nerve, ureter, tendon) which results in any of the following:

    - Penetration, perforation or any other type of entry into its lumen
    - Need for repair (exceeds simply placing sutures in the serosal/muscular layer) or other procedural intervention
    - Need for organ removal

- **Repair** can include but is NOT LIMITED to the following:

    - Repair of a major blood vessel
    - Closure of a perforation
    - Bowel or organ resection
    - Anastomosis
    - Revision or reconstruction

- **Other procedural interventions** include but are NOT LIMITED to the following:

    - Control of bleeding in the liver or spleen
    - Placement of stent, drain, catheter, or tube (e.g., T-tube, chest tube, nephrostomy tube, gastrostomy tube)
    - Any scopic examination (e.g., laparoscopy, endoscopy, colonoscopy, bronchoscopy)
    - Operative procedure
    - Examination under anesthesia (EUA)
    - Repeat of the initial procedure
    - Angioplasty
    - Other invasive procedure
    - Resuscitative measures

- Any intraoperative or intraprocedural injury which fits the above definition, even if it is referred to as an "incidental" nick or injury, is to be captured as an 801.

- An 801 occurrence may require an 819 secondary entry. Please reference general instructions.

EXAMPLES:

Include:

- Esophageal tear occurs during intubation. No repair but 10 days later patient develops retropharyngeal and mediastinal abscesses and pharyngeal fistula; patient requires gastrostomy tube, thoracotomy and chest tub (examples of other procedural interventions).
- A tear to the small bowel while lysing adhesions during hysterectomy results in a need for a small bowel resection.
- "Incidental nick" results in entry into the bladder which requires placement of suture(s).

Exclude:

- Tear to only the serosa in the small bowel requiring suture(s).
- Patient requires RTOR for hemorrhage; diffuse oozing not due to any injury is identified and controlled.
- Bile leak occurs in connection with excision of a hepatoma, repair is required (the injury occurred during direct operation on the liver).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **regardless of setting** • **within 30 days of the procedure** • **include readmissions.**	803.	Hemorrhage or hematoma requiring drainage, evacuation or other procedural intervention or results in serious injury or death.	Expected non-symptomatic blood loss related to the procedures. • Post-cardiopulmonary bypass blood deperasias • Related to disease process

NOTE:

- Bleeding that is attributable to a specific **intraoperative or intraprocedural** injury is submitted as an 801. Bleeding that occurs during laparoscopic procedure and results in unplanned conversion.

- **Other procedural interventions** include but are NOT LIMITED to the following:

    - Blood transfusions
    - Control of bleeding in a procedure room or operating room
    - Placement of stent, drain, catheter, or tube (e.g., T-tube, J-tube, chest tube, nephrostomy tube, gastrostomy tube)
    - Any scopic examination (e.g., laparoscopy, endoscopy, colonoscopy, bronchoscopy)
    - Operative procedure
    - Examination under anesthesia (EUA)
    - Repeat of the initial procedure
    - Angioplasty
    - Other invasive procedure
    - Resuscitative measures

- Repetitive occurrences (e.g., multiple occurrences involving hemorrhage or hematoma in connection with a previous procedure) each need to be submitted.

If the drainage, evacuation or other procedural intervention occurs in the operating room, regardless of the setting of the original procedure, enter 803 in the 1st occurrence code field and add 819 in the 2nd occurrence code field.

“Serious Injury”, “life threatening”, or “harm” requires the patient to undergo significant additional diagnostic or treatment measures.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **Regardless of setting** • **Within 30 days of the procedure** • **Include readmissions**	806.	Displacement, migration or breakage of an implant, device, graft, or drain, whether repaired, intentionally left in place or removed.	806. Occurrences reported in 913 (retained foreign body) or occurrences due to equipment malfunction or device product reported in 937 or 938.

NOTE:

Device includes but NOT LIMITED to:

- Catheter
- Wire
- Screw

Hip prosthesis dislocation should be reported as 806.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **Regardless of setting** • **Within 30 days of the procedure** • **Include readmissions**	808.	Post-op wound infection following clean or clean/contaminated case. ASA class is required to be noted.	808. Contaminated or dirty case procedure.

NOTE:

- Wound Class

  Assessment of likelihood and degree of microbial contamination of surgical wound at time of operation. National Nosocomial Infection Surveillance (NNIS) wound class is the Centers for Disease Control and Prevention's adaptation of the American College of Surgeons' wound classification schema. Definitions of the four wound classes are as follows:

- Clean (I): Uninfected operative wounds in which no inflammation is encountered and respiratory, alimentary, genital, or uninfected urinary tracts are not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow nonpenetrating (blunt) trauma should be included in this category if they meet criteria.

  - Clean-contaminated (II): Operative wounds in which respiratory, alimentary, genital or uninfected urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving biliary tract, elective appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in technique is encountered.

  - Contaminated (III): Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (e.g., open cardiac massage) or gross spillage from gastrointestinal tract, and incisions in which acute, nonpurulent inflammation is encountered are included in this category.

  - Dirty/infected (IV): Old traumatic wounds with retained devitalized tissue and those wounds that involve existing clinical infection or perforated viscera. This definition suggests that organisms causing postoperative field before operation.

- American Society of Anesthesiology (ASA) Score

An assessment by the anesthesiologist of a patient's preoperative physical condition that uses the ASA Classification of Physical Status schema. Definitions of classification codes are as follows:

1. Normally healthy patient.
2. Patient with mild systemic disease.
3. Patient with severe systemic disease.

4. Patient with an incapacitating systemic diseases that is a constant threat to life.
5. Moribund patient who is not expected to survive for twenty-four (24) hours with or without operation.

- Infection Site: Surgical site infection (superficial incisional)

Definition: A superficial SSI must meet the following criterion: Infection occurs within thirty (30) days after the operative procedure and involves only skin and subcutaneous tissue of the incision and patient has at least one of the following:

a. purulent drainage from the superficial incision
b. organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision
c. at least one of the following signs or symptons of infection: pain or tenderness, localized swelling, redness or heat, and superficial incision is deliberately opened by surgeon, unless incision is culture-negative.
d. Diagnosis of superficial incisional SSI by the surgeon or attending physician.

Infection Site: Surgical site infection (deep incisional)

Definition: A deep incisional SSI must meet the following criterion: Infection occurs within thirty (30) days after the operative procedure if no implant is left in place or within one year if implant is in place an the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision and patient has at least one of the following:

a. purulent drainage from the deep incision but not from the organ/space component of the surgical site.
b. a deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (>38°C or 100.4°F), or localized pain or tenderness, unless incision is culture-negative.
c. an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
d. diagnosis of a deep incisional SSI by a surgeon or attending physician.

Infection Site: Surgical site infection (organ/space)

Definition: An organ/space SSI involves any part of the body, excluding the skin incision, fascia, or muscle layers, that is opened or manipulated during the operative procedure. Specific sites are assigned to organ/space SSI to further identify the location of the infection.

An organ/space SSI must meet the following criterion: Infection occurs when thirty (30) days after the operative procedure if no implant is left in place or within one year if implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and infection involves any part of the body, excluding the skin incision, fascia or muscle layers, that is opened or manipulated during the operative procedure and patient has at least one of the following:

a. purulent drainage from a drain that is placed through a stab wound into the organ/space.
b. Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
c. An abscess or other evidence of infection involving the organ/space that found on direct examination, during reoperation, or by histopathologic or radiologic examination
d. Diagnosis of an organ/space SSI by a surgeon or attending physician.

Infection Site: Vaginal Cuff

Definition: Vaginal cuff infections must meet at least one of the following criteria:

Criterion 1: Posthysterectomy patient has purulent drainage from the vaginal cuff.
Criterion 2: Posthysterectomy patient has an abscess at the vaginal cuff.
Criterion 3: Posthysterectomy patient has pathogens cultured from fluid or tissue obtained from the vaginal cuff.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure Related • **Regardless of setting** • **Within 30 days of the procedure** • **Include readmissions**	819.	Any unexpected operation or reoperation (RTOR) related to the primary procedure, regardless of setting of primary procedure. (If occurrence involves 801 or 803-808, enter 801 or 803-808 in the 1st occurrence code field, followed by 819 in the 2nd occurrence code field.)	Non-anesthesia procedural interventions (e.g., ERCP) usually performed in special procedure rooms in larger hospitals but which are performed in the OR in a smaller hospital simply due to lack of specialized facilities. Procedures that are commonly sequential or repeated (skin flaps, colostomy closure, 2nd look for ischemia after bowel resection or whenever intestinal ischemia is expected. Also lap 2nd look post oncologic procedure when post-op adjuvant therapy was given (ovarian cancer, Hodgkin's and non-Hodgkins lymphoma). Excludes debridement, vascular cases where conservative approach tried first (thrombectomy, fem-pop bypass) but ultimately fails (BKA done as last resort).

INTENT:

To capture any **unexpected visit to the OR** for an operation or reoperation in connection with a previous procedure, regardless of the setting of the previous procedure (e.g., Radiology Department, special procedure room or outpatient clinic treatment room).

NOTE:

Whenever an 801-808 occurrence involves an unexpected operation or RTOR (819) following completion of the original procedure regardless of setting, the report should be completed in the following manner:

1) enter 801, 803, 806, or 808 in the 1st occurrence code field
2) enter 819 in the 2nd occurrence code field

Whenever an unexpected operation or RTOR (819) is not associated with an occurrence in the 801-808 range, enter the 819 in the first occurrence field and include an explanation in the narrative of the cause for the return or a detail code in the 900 range.

The purpose for the order in which the codes are entered is important for data analysis. To analyze unplanned or unexpected operations or reoperations: one query for the 819 code alone in the 1st occurrence code field, and a second query for those occurrence codes 801 and 803-808 in the 1st occurrence code field which also have the 819 code in the 2nd occurrence code field.

Consider the 900 category codes in addition to the 800 category codes, when applicable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	851.	Hysterectomy in a pregnant woman	

NOTE:

- All other obstetrical occurrences should be tracked or reported through existing categories. For example, maternal deaths would be reported as code 915.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	853.	Ruptured uterus	

NOTE:

- All other obstetrical occurrences should be tracked or reported through existing categories. For example, maternal deaths would be reported as code 915.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	854.	Circumcision requiring repair	854. Planned suture during procedure.

NOTE:

- Wrong infant circumcised would be coded as 911 “Wrong patient-wrong site”.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Procedure related • **Regardless of setting** • **Include readmissions**	855.	Incorrect Procedure or incorrect Treatment that is Invasive	855. Venipuncture for phlebotomy, diagnostic tests without contrast agents.

NOTE:

- Invasive procedures or treatment – involves puncture or incision of the skin or insertion of an instrument or foreign material into the body.

- Medication errors resulting in adverse outcomes should be reported under 108-110 and corresponding 900 code category (915-919).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	900s category		915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission).

NOTE:

- **When making a determination for submission as an unexpected death, consider the question "Did you think the patient was likely to die when admitted to the facility"?**

- If more than one detail code (codes in the 900 series) applies, select the one that describes the most severe outcome or issue (e.g., if a cardiac arrest occurs that results in a death, use code 915 (death).

EXAMPLES:

- Sepsis related to opportunistic infection (e.g., C. Difficile) resulting from antibiotic therapy is NOT reportable (e.g., sepsis from C. Difficile infection due to antibiotic therapy for pneumonia, which results in death).

- Adverse occurrences are not automatically dismissed from reportability because a patient is significantly compromised by underlying illness or condition (e.g., if a patient with ESRD and significantly cardiac disease exhibits S&S of hemorrahage s/p hip repair and suffers an MI and expires before the hemorrhage can be controlled, it would be reportable as a 915).

- Adverse occurrences are not automatically dismissed from reportability because a patient develops a known complication to a procedure or treatment. An event would be reportable under codes 915-919 if the known complication is unintended or undesirable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	901.	All other unusual events or accidents warranting DOH notification, not covered by other codes.	

NOTE:

- Submissions within this category should be infrequent.

EXAMPLE:

- Kidney intended for transplant erroneously discarded and retrieved from trash. Transplant continued as still within window of opportunity for surgery.

- During delivery, mother kicked obstetrician causing him/her to be pushed away, instruments scattered. Baby expelled to floor.

- Definition of Unusual Incidents:

  An unusual incident is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient or the abuse of a patient.

  The Department uses the following definitions as a guide for determining what needs to be reported:

  - "Serious injury" means injury that is life threatening, results in death, or requires a patient to undergo significant additional diagnostic or treatment measures.

  - "Other serious incidents that seriously affect the health and safety of patients" means incidents that result in serious injury.

  - Please refer to the examples for guidance in deciding which incidents are reportable to the Department.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	911.	Wrong Patient, Wrong Site – Surgical Procedure	

NOTE:

- Surgical procedures include any procedures performed in the operating room or ambulatory surgery center.
- Other invasive procedures performed on wrong patient/wrong site should be reported as 912.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	913.	Unintentionally retained foreign body.	913. Foreign bodies retained due to equipment malfunction or defective product (report under 937 or 938) or those reported under 806.

NOTE:

- Also code the occurrence as an 819 if it requires an unplanned operation (RTOR) to remove or address the retained foreign body.

EXAMPLES:

Inaccurate surgical count or break in procedural technique (sponges, lap pads, instruments, guidewires from central line insertion, cut intravascular cannulas, needles, etc.).

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	915.	Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in: Death (e.g., brain death).	915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission) including cardiac diseases and Dementia Dx. Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938.

NOTE:

- The unexpected adverse occurrence does not infer that it has to be procedure or treatment related.

INCLUDE:

- All maternal deaths are reportable.
- All deaths in a full term infant weighing > 2500gms with no congenital anomalies are reportable.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	917.	Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in: Loss of limb or organ.	915-919. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission, Dementia Dx). Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938.

NOTE:

- When making a determination for submission as a loss of limb or organs, consider the question "Did you think the patient was likely to lose a limb or organ when admitted to the facility?"

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CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	918.	Any unexpected adverse occurrence not directly related to the natural course of the patient's illness or underlying condition resulting in: Impairment of limb (limb unable to function at same level prior to occurrence) and impairment present at discharge or for at least two (2) weeks after occurrence if patient is not discharged.	915-920. Any unexpected adverse occurrence directly related to the natural course of the patient's illness or underlying condition (e.g., terminal or severe illness present on admission including Dementia Dx). Any cases involving malfunction of equipment resulting in death or serious injury should be reported under 938. 918. Limb functions at the same level as prior to the occurrence, impairment resolves by discharge or within two weeks if not discharged. Excludes positioning parathesias.

NOTE:

When making a determination for submission as an impairment of a limb, consider the question "Did you think the patient was likely to develop an impairment of a limb when admitted to the facility?"

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	921.	Crime resulting in death or serious injury to a patient, as defined in 915-919.	

NOTE:

- A crime is any action that is legally prohibited or is any serious violation of a public law after law enforcement has made determination.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	922.	Suicides and attempted suicides with serious injury as defined in 915-919.	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	923.	Elopement from the facility resulting in death or serious injury as defined in 915-919.	923. Cases in which the patient outcome would have been the same whether or not the elopement occurred (cancer death, etc.).

The definition of elopement was defined and accepted as “unauthorized exit from the facility property of a cognitively impaired resident without staff awareness”.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	931.	Strike by facility staff.	

Strike is defined as collective work stoppage by facility staff.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	932.	External disaster outside the control of the facility which affects facility operations.	932. Situations that are related to termination of service should be reported under 933.

NOTE:

Reporting under this occurrence code relates specifically to natural or catastrophic disasters.

EXAMPLE:

- Earthquakes
- Bioterrorism
- Bomb Threat

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	933.	Termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.	

NOTE:

Any major equipment failure should be reported under 937, 938 or 932.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	934.	Poisoning occurring within the facility (water, air, food, or ingestion).	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	935.	Facility fire disrupting patient care or causing harm to patients or staff.	
	936.	All other fires.	

NOTE:

- This code should be used to identify any fires which result in cancellation or delay of any patient care services or result in any movement of patients.
- A fire resulting in a patient death or serious injury should be reported under 915-919.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	961.	Infant Abduction.	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	962.	Adult Abduction	

EXAMPLE:

Patient or resident removed from facility without facility knowledge and/or power of attorney and/or medical approval.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Events	963.	Rape of a patient, resident, staff.	964. Non-physician interventions and appropriate facility interventions.
	964.	Resident/Patient to Resident/Patient altercations (nursing homes, Homes for the Aged, ACLF, A&D facilities would only report those that required physician intervention).	
	966.	Restraint related incident.	
	967.	Infant discharged to wrong family.	
	968.	Physical Abuse.	
	969.	Sexual Abuse.	
	970.	Verbal Abuse.	
	971.	Neglect or Self-Neglect.	
	972.	Misappropriation of Funds.	

EXAMPLE:

- Inappropriate contact (sexual) between patient and staff.

NOTE:

Nursing homes should refer to specific definitions under nursing home regulations and Linton Law for resident abuse, neglect, or misappropriation of funds.

Definition of Abuse: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm, pain, or mental anguish.

Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Misappropriation of resident property: The deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Other Serious Event	967.	Infant discharged to wrong family.	

JE/G4010185-hlrev/BHLR

TENNESSEE IMPROVING PATIENT SAFETY (TIPS) COALITION MEMBERSHIP LIST

ORGANIZATION REPRESENTED	MEMBERS	TELEPHONE & FAX	ADDRESS
Department of Health	Kenneth S. Robinson, MD	P 615-741-3111	425 5th Ave North, 3rd Floor, Cordell Hull Bldg. Nashville, TN 37247
Department of Health	Judy Eads, Assistant Commissioner judy.eads@state.tn.us	P 615-741-8404 F 615-741-5542	425 5th Ave North, 1st Floor, Cordell Hull Bldg. Nashville, TN 37247
Department of Health	Tom Sharp/Paige Edwards Legislative Liaisons	P 615-741-3111	425 5th Ave North, 3rd Floor, Cordell Hull Bldg. Nashville, TN 37247
Department of Health	Shirley Corry shirley.corry@state.tn.us	P 615-741-1611 F 615-532-3386	312 8th Avenue North 26th Floor, William R. Snodgrass Nashville, TN 37247-0120
Department of Health	Katy Gammon Director of Health Care Facilities katy.gammon@state.tn.us	P 615-741-7532 F 615-741-7051	425 5th Ave North, 1st Floor, Cordell Hull Bldg. Nashville, TN 37247
Department of Health	Cathy Green, Director of Licensure cathy.c.green@state.tn.us	P 615-532-6595 F 615-741-7051	425 5th Ave North, 1st Floor, Cordell Hull Bldg. Nashville, TN 37247
Board of Medical Examiners	Allen S. Edmonson, MD badams@utmem.edu	P 901-458-9349 F 901-448-6062	666 Center Drive Memphis, TN 38112
Tennessee Medical Association	George L. Eckles, Jr., MD geckles@ix.netcom.com	P 615-867-7857 F 615-893-1769	Murfreesboro Medical Clinic 1004 North Highland Avenue Murfreesboro, TN 37130
Board of Pharmacy	Paula B. Hinson, DPh paula.hinson@bmhcc.org	P 901-226-4582 F 901-226-5792	7364 Stout Road Germantown, TN 38138
Board of Nursing	Cheryl Stegbauer, RN cstegbauer@utmem.edu	W 901-448-8083 H 901-761-4996 F 901-761-4175	5570 King's Point Memphis, TN 38120
Board of Dentistry	Charles L. Rogers, DDS	P 931-728-2026 F 931-728-3076	202 Hillwood Circle Manchester, TN 37355
Board of Osteopathic Examiners	Joyce Ann Brown, DO Jabdomph42@yahoo.com	P 615-717-4400 F 615-717-4433	Professional Medical Group 5245 Mt. View Parkway, Suite D – PO Box 1244 Antioch, TN 37011-1244
Board for Licensing Health Care Facilities	Ronald B. Arrison rarrison@kdshome.com	P 901-272-7405 F 901-272-7422	3568 Appling Road Bartlett, TN 38133
TennCare	Kasi Tiller Director , Quality Oversight	P 615-741-8170 F 615-741-0064	Metro Center Nashville, TN
TennCare	Wendy Long, M.D. Medical Director wendy.long@state.tn.us	P 615-741-0213	Metro Center Nashville, TN
Tennessee Pharmacists Association	Baeteena Black bblack@tnpharm.org	P 615-256-3023 F 615-255-3528	500 Church Street, Suite 650 Nashville, TN 37219
Tennessee Medical Association	David Garriott, MD President	P 423-247-5553 F 423-247-9254	914 Broad Street, Suite 3-A Kingsport, TN 37660
Tennessee Hospital Association	Chris Clarke - cclarke@tha.com Jeannine Briley – jbriley@tha.com	P 615-401-7434 F 615-242-4803	500 Interstate Blvd. South Nashville, TN 37210-4634
Tennessee Hospital Association	Bill Hubbard whubbard@whbdlaw.com	P 615-251-5446	c/o Weed Hubbard Suite 1420, 210 4th Avenue North Nashville, TN 37219
Hospital Alliance of Tennessee	LaDonna McDaniel ladonna@hospitalalliancetn.com	P 615-254-1941 F 615-254-1942	211 7th Avenue North, Suite 400 Nashville, TN 37219
Hospital Alliance of Tennessee	Paige Kisber, President paige@hospitalalliancetn.com	P 615-254-1941 F 615-254-1942	211 7th Avenue North, Suite 400 Nashville, TN 37219
Tennessee Nurses Association	Deanna Menesses dmenesses@tnaonline.org	P 615-254-0350 F 615-254-0303	545 Mainstream Drive, Suite 405 Nashville, TN 37228
Tennessee Nurses Association	Wanda Hooper whooper@stthomas.org	P 615-222-3806 F 615-222-6616	4487 Post Place Nashville, TN 37205
Tennessee Osteopathic Medical Association	Dee Ann Walker	P 615-242-3032	200 4th Avenue North, Suite 900 Nashville, TN 37219
Tennessee Bar Association	Charles Swanson, President	P 615-383-7421	221 4th Avenue North, Suite 400 Nashville, TN 37219
Tennessee Health Care Association	Chris Puri - cpuri@thca.org Laura Savage – lsavage@thca.org	P 615-834-6520 F 615-834-2502	2809 Foster Avenue Nashville, TN 37210
Tennessee Association of Homes & Services for the Aged	Carrie Ermshare cermshar@tha.com	P 615-256-1800	500 Interstate Blvd. South Nashville, TN 37210-4634
Department of Human Services Adult Protective Services	Nancy Jackson nancy.jackson@state.tn.us	P 615-313-4785 F 615-741-4165	Citizens Plaza, 400 Deaderick Nashville, TN 37248-9700
Healthcare 21	Gaye Fortner gfhc21@bellsouth.net	P 865-292-2121	620 Market Street, Suite 320 Knoxville, TN 37902

TENNESSEE IMPROVING PATIENT SAFETY (TIPS) COALITION MEMBERSHIP LIST

ORGANIZATION REPRESENTED	MEMBERS	TELEPHONE & FAX	ADDRESS
JCAHO – Joint Commission on Accreditation of Healthcare Organizations	Mark Crafton, Executive Director State & External Relations mcrafton@jcaho.org	P 630-792-5260 F 630-792-4261	One Renaissance Blvd. Oakbrook Terrace, IL 60181
Commission on Aging and Disability	Nancy Peace nancy.peace@state.tn.us	P 615-741-2056 F 615-741-3309	Andrew Jackson Bldg., Suite 825 500 Deaderick Street Nashville, TN 37243-0860
Hospital/Long Term Care	Jill Fainter jill.fainter@hcahealthcare.com	P 615-344-5865 F 615-344-8188	2555 Park Place Nashville, TN 37203
Center for Healthcare Quality	Albert Grobmyer III, MD algvol@aol.com	P 901-682-0381 F 901-761-3786	3175 Lenox Park Blvd., Suite 309 Memphis, TN 38115
Consumer	Pat Eubanks pat9323@cs.com	P 865-966-9323 F 865-521-8283	1232 Lovell Road Knoxville, TN 37932
Consumer	Marilyn Whalen mmw37027@comcast.net		
INSURANCE INDUSTRY			
State Volunteer Mutual	Connie Bellamy connieb@svmic.com	P 615-846-8319	P.O. Box 1065 Brentwood, TN 37024
Blue Cross Blue Shield	Steven Coulter, MD, Sr.V.P. Med. Affairs/Bill Cecil bill_cecil@bcbst.com	P 423-763-3028	801 Pine Street Chattanooga, TN 37402-2555
Managed Care – TennCare Division	Ken Okolo, Ph.D. ken.okolo@state.tn.us	P 615-741-0213	729 Church Street Nasvhille, TN 37243-6501
Department of Commerce & Insurance	Stephani (Lassiter) Ryan stephani.ryan@state.tn.us	P 615-741-2218	Davy Crockett Tower, 4th Floor 500 James Robertson Parkway Nashville, TN 37243
Omnicare Health Plan, Inc.	Osbie Howard, CEO	P 901-346-0064 F 901-348-2212	1991 Corporate Avenue, 4th Floor Memphis, TN 38132
United Healthcare of Tennessee, Inc.	Darlene DuLac darlene_a_dulac@uhc.com	P 615-372-3617	10 Cadillac Drive, Suite 200 Brentwood, TN 37027
HEALTH PURCHASERS			
United Parcel Service, Inc.	Carl Westley	P 615-885-8450 F 615-885-8432	705 Massman Drive Nashville, TN 37210
Department of Finance & Administration	John Anderson john.g.anderson@state.tn.us	P 615-741-8642 F 615-741-8196	Division of Insurance Administration 312 Eighth Avenue North 13th Floor, William R. Snodgrass Nashville, TN 37243
Saturn Corporation	Dr. Sharon Stewart	P 931-486-5754 F 931-489-4154	100 Saturn Parkway P.O. Box 1503, MD 371-995-K09 Spring Hill, TN 37174
Veterans Administration	Gloria Williams, RN Patient Safety Officer gloria.williams@med.va.gov	P 615-695-2191 F 615-695-2210	1801 West End Avenue, Ste. 1100 Nashville, TN 37203
The Kroger Company	Phil Howard, Risk Management	P 615-871-2947	2620 Elm Hill Pike Nashville, TN 37214
LEGISLATORS			
Senator	Thelma Harper sen.thelma.harper@legislature.state.tn.us	P 615-741-2453	2 Legislative Plaza Nashville, TN 37243-0219
Senator	Diane Black sen.diane.black@legislature.state.tn.us	P 615-230-8586 F 615-253-0207	309 War Memorial Bldg. Nashville, TN 37243-0218
Representative	Joe Armstrong rep.joe.armstrong@legislature.state.tn.us	P 615-741-0768 F 615-253-0316	25 Legislative Plaza Nashville, TN 37243-0115
Representative	Susan Lynn rep.susan.lynn@legislature.state.tn.us	P 615-741-7462 F 615-253-0322	202A War Memorial Bldg. Nashville, TN 37243-0157
SCHOOLS			
Vanderbilt University School of Nursing	Dean Colleen Conway-Welch, PhD Susan Cooper	P 615-343-8876 F 615-343-7711	110 Godchaux Hall Nashville, TN 37240
U.T. Medical School	Henry G. Herrod, MD, Dean	P 901-448-5529	62 South Dunlap Hyman Building Memphis, TN 38163
Vanderbilt University Office of General Counsel	Mary Jo Price, University Counsel	P 615-322-5157 F 615-936-0329	2100 West End Avenue, Suite 750 Nashville, TN 37203

TIPS Home Page
TIPS Awards Program
2004 TIPS Symposium
2005 TIPS Symposium Announcement (PDF)
Agenda
Acknowledgements
2004 Award Winners

Tennessee Improving Patient Safety

Tennessee Improving Patient Safety Awards Program

Want to share a creative solution with others? Have you had a successful patient safety project?

The Tennessee Improving Patient Safety (TIPS) Award recognizes health care organizations for achievement in reducing the risk of medical errors and improving patient safety and medical outcomes in Tennessee

- **Overview**
- **Program Description**
- **Application** **(PDF)**
- **Timeframe for 2005 Awards**

OVERVIEW IN IMPROVING PATIENT SAFETY AWARD PROGRAM

The goals of the Patient Safety Awards Program are to raise awareness of the need for an organizational commitment to exceptional patient-centered efforts to create and improve systems that will ultimately improve the quality of care and to communicate successful programs and strategies to other health care providers.

The Tennessee Improving Patient Safety Awards Program honors healthcare organizations that:

1. Have committed to achieving health care that is patient centered and system based.
2. Can document progress in achieving multiple aims.
3. Can demonstrate proven reduction in errors and/or risk of errors with improvements in patient safety and quality of care.

PROGRAM DESCRIPTION

Categories

There are six categories to be recognized: (1) Hospitals under 100 beds, (2) Hospitals with 100-299 beds, (3) Hospitals over 300 beds, (4) Long Term Care- Nursing Homes, (5) Long Term Care- Assisted Care Living and Residential Homes for the Aged, and (6) Other- includes, but not limited to Ambulatory Surgical Treatment Centers, Alcohol and Drug Centers, Private MD practices, End-Stage Renal Dialysis clinics, etc.

Evaluation Components

In the submitted application, each applicant must demonstrate participation in or implementation of programs/initiatives that have been proven to reduce errors and/or risk of errors, improve patient safety and outcomes. The program/initiative must have been developed and implemented for at least six months in order to be considered. Each application will be evaluated on a point system based on the following components:

- Data driven (20%)
- Creativity and innovation (20%)
- Practical to implement and administer (10%)
- Leadership commitment and support (20%)
- Transferable across settings and organizations (10%)
- Performance Improvement action(s) and results (10%)
- Multi-disciplinary team participation (10%)

For unbiased evaluation by the TIPS' Awards Committee, the applications will be blinded throughout the process. This evaluation committee will be composed of representatives from the Tennessee Improving Patient Safety Coalition who have expertise in quality and patient safety.

Dissemination

Award winning achievements will be published on the Tennessee Department of Health website at www.tennessee.gov/health/ as well as, through local newspapers, newsletters and other publications.

Instructions

- To blind the process, applications must have **no references to the organization or facility name**, or any other demographic information that would allow identification during the evaluation process.

- The applicant Demographic Information form must be completed and submitted with the entry.

- An organization may submit multiple applications if they have more than one project they would like to have evaluated

- An abstract must accompany each submission. The abstract can not have more than 500 words. Each entry must be typed, single spaced and able to fit on 81/2 by 11 inch paper using a size 10 or larger font. A narrative explanation of the improvement project should accompany the abstract and describe how the project addressed the key evaluation components: data driven, creativity; practicality; leadership commitment and support;

transferable across settings; performance improvement actions and results; multi-disciplinary teams. Each page should have a heading and a page number. Five additional pages are allowed for the graphs, figures and data tables that should be part of the appendices. Graphs should be in black and white.

- Entries must be submitted via electronic email with an attachment in a MS Word (97 or newer version) format.

- Entries must be either hardcopy with disk copy of project or via electronic email with an attachment in a MS Word (97 or newer version) format. Entries should be submitted to:

Connie Bellamy at email address: connieb@svmic.com
Or mail to: Connie Bellamy
State Volunteer Mutual Insurance Company
P.O. Box 1065
Brentwood, TN 37024

- All Applicants must develop a poster presentation of their safety improvement project for display at the Annual Tennessee Patient Safety Symposium.

Entry Deadline

Date and time will be established each year and communicated in advance of the symposium. The 2005 deadline is 5:00 pm CST June 30, 2005.

Fee

There is no fee to submit an application for the Tennessee Improving Patient Safety (TIPS) Award program.

Possible Topic Areas

Award applications should consider the following topics. (Source: National Patient Safety Foundation Solutions Initiative 2000)

- **Non-Punitive Environment for Error Reporting and Disclosure**
  Solutions that have overcome the environmental barriers to error reporting, diagnosis, and disclosure. Non-punitive ways to measure errors that lead to better understanding of the causes and of failure. Indicators or ways to identify the potential for error.

- **Clinical Solutions**
  Ways to reduce errors, i.e., in anesthesia, diagnostics, surgery, medication dispensing, etc.

- **Systems Error Reduction**
  Ways leadership can foster environments that support error disclosure and ameliorate internal cultural obstacles that may impede safer health care practices. Human factors, risk management, and other strategies that have improved patient safety.

- **Technical Solutions**
  Innovations in the product development sector that assist systems and clinicians in measurably reducing the incidence of error, avoidable patient injury, and associated costs.

- **Educational Solutions**

"Systems learning" approaches that encourage deeper understandings of error, responsibility and the dynamic interaction between human, technological, and organizational factors in high-risk settings.

- **Cultural Solutions**
  Patient empowerment programs and productive patient/clinician partnership approaches to prevent harm. Innovation in the development of values systems, incentives alignment, consumer outreach activities, and communication and information feedback programs.

- **Environmental Solutions**
  Ways to modify the legal environment, which currently emphasizes fault and punishment. Alternative ways of resolving claims of patient injury. Innovative use of legal or alternative dispute mechanisms to promote accountability and prevent injury. Ways the media have advanced patient rights and drawn attention to patient safety. Strategies used by accrediting and regulatory agencies to maintain standards for measurement and accountability, while simultaneously fostering an external environment that stimulates the disclosure of information about risk and error.

- **Patient Provider Communication Solutions**
  Demonstrated strategy and results to improve care delivery and patient satisfaction through enhanced patient-physician communication. Effective and appropriate education and intervention programs in place for health care providers at risk.

TIMEFRAME FOR 2005 AWARDS

Date	Activities
June 30, 2005 at 5:00 PM	All applications for the TIPS Awards must be received by the awards program chairperson
August 15, 2005	All winners will be notified
September 14, 2005	Presentation of awards to all winners

Department of Health
Cordell Hull Building, 3rd Floor
Nashville, TN 37247-0101
615.741.3111

Appendix V.

Definitions of Patient Safety Indicators

Complications of Anesthesia

Definition	Cases of anesthetic overdose, reaction, or endotrachial tube misplacement per 1,000 surgery discharges.
Numerator	Discharges with ICD-9-CM diagnosis codes for anesthesia complications in any secondary diagnosis field per 1,000 discharges.
Denominator	All surgical discharges defined by specific DRGs. Exclude patients with codes for poisoning due to anesthetics (E8551, 9681-4, 9687) and any diagnosis code for active drug dependence, active nondependent abuse of drugs, or self-inflicted injury.
Empirical Performance	Rate: 0.55 per 1,000 population at risk Bias: Not detected, but may be biased in a way undetectable by empirical tests.
Risk adjustment	Age, sex, DRG, comorbidity categories.

Death in Low-Mortality DRGs

Definition	In-hospital deaths per 1,000 patients in DRGs with less than 0.5% mortality.
Numerator	Discharges with disposition of "deceased" per 1,000 population at risk.
Denominator	Patients in DRGs with less than 0.5% mortality rate, based on NIS 1997 low-mortality DRG. If a DRG is divided into "without/with complications," both DRGs must have mortality rates below 0.5% to qualify for inclusion. Exclude patients with any code for trauma, immunocompromised state, or cancer.
Empirical performance	Rate: 0.66 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted.
Risk adjustment	Age, sex, DRG, comorbidity categories.

Decubitus Ulcer

Definition	Cases of decubitus ulcer per 1,000 discharges with a length of stay greater than 4 days.
Numerator	Discharges with ICD-9-CM code of 7070 in any secondary diagnosis field per 1,000 discharges.
Denominator	All medical and surgical discharges defined by specific DRGs. Include only patients with a length of stay of 5 or more days. Exclude patients in MDC-9 or patients with any diagnosis of hemiplegia, paraplegia, or quadriplegia. Exclude obstetrical patients in MDC 14. Exclude patients admitted from a long-term care facility.
Empirical Performance	Rate: 22.7 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted.
Risk Adjustment	Age, sex, DRG, comorbidity categories.

Failure to Rescue

Definition	Deaths per 1,000 patients having developed specified complications of care during hospitalization.
Numerator	Discharges with a disposition of "deceased" per 1,000 population at risk.
Denominator	Discharges with potential complications of care listed in failure to rescue definition (i.e., pneumonia, DVT/PE, sepsis, acute renal failure, shock/cardiac arrest, or GI hemorrhage/acute ulcer). Exclusion criteria specific to each diagnosis. Exclude patients age 75 years and older. Exclude neonatal patients in MDC 15. Exclude patients transferred to an acute care facility. Exclude patients transferred from an acute care facility. Exclude patients admitted from a long-term care facility.
Empirical Performance	Rate: 148.4 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted.
Risk Adjustment	Age, sex, DRG, comorbidity categories.

Latrogenic Pneumothorax

Definition	Cases of iatrogenic pneumothorax per 1,000 discharges.
Numerator	Discharges with ICD-9-CM code of 512.1 in any secondary diagnosis field per 1,000 discharges.
Denominator	All discharges. Exclude patients with any diagnosis of trauma. Exclude patients with any code indicating thoracic surgery or lung or pleural biopsy or assigned to cardiac surgery DRGs. Exclude obstetrical patients in MDC 14.
Empirical Performance	Rate: 0.83 per 1,000 population at risk. Bias: Some bias demonstrated
Risk Adjustment	Age, sex, DRG, comorbidity categories

Selected Infections Due to Medical Care

Definition	Cases of ICD-9-CM codes 9993 or 99662 per 1,000 discharges.
Numerator	Discharges with ICD-9-CM code of 9993 or 99662 in any secondary diagnosis field per 1,000 discharges.
Denominator	All medical and surgical discharges defined by specific DRGs. Exclude patients with any diagnosis code for immunocompromised state or cancer.
Empirical Performance	Rate: 1.99 per 1,000 population at risk. Bias: Some bias demonstrated
Risk Adjustment	Age, sex, DRG, comorbidity categories

Foreign Body Left During Procedure

Definition	Discharges with foreign body accidentally left in during procedure per 1,000 discharges.
Numerator	Discharges with ICD-9-CM codes for foreign body left in during procedure in any secondary diagnosis field per 1,000 surgical discharges.
Denominator	All medical and surgical discharges defined by specific DRGs.
Empirical Performance	Rate: 0.09 per 1,000 population at risk. Bias: Did not undergo empirical testing of bias.
Risk Adjustment	Age, sex, DRG, comorbidity categories.

Postoperative Hemorrhage or Hematoma

Definition	Cases of hematoma or hemorrhage requiring a procedure per 1,000 surgical discharges
Numerator	Discharges with ICD-9-CM codes for postoperative hemorrhage or postoperative hematoma in any secondary diagnosis field and code for postoperative control of hemorrhage or drainage of hematoma (respectively) in any secondary procedure code field per 1,000 discharges. Procedure code for postoperative control of hemorrhage or hematoma must occur on the same day or after the principal procedure. Note: If day of procedure is not available in the input data file, the rate may be slightly higher than if the information was available.
Denominator	All surgical discharges defined by specific DRGs. Exclude obstetrical patients in MDC 14.
Empirical Performance	Rate: 1.61 per 1,000 population at risk. Bias: Not detected in empirical tests
Risk Adjustment	Age, sex, DRG, comorbidity categories

Postoperative Hip Fracture

Definition	Cases of in-hospital hip fracture per 1,000 surgical discharges.
Numerator	Discharges with ICD-9-CM code for fracture in any secondary diagnosis field per 1,000 surgical discharges.
Denominator	All surgical discharges defined by specific DRGs. Exclude all patients with diseases and disorders of the musculoskeletal system and connective tissue (MDC 8). Exclude patients with principal diagnosis codes for seizure, syncope, stroke, coma, cardiac arrest, anoxic brain injury, poisoning, delirium or other psychoses, trauma. Exclude patients with any diagnosis of metastatic cancer, lymphoid malignancy, bone malignancy or self-inflicted injury. Exclude obstetrical patients in MDC 14. Exclude patients 17 years of age or younger.
Empirical Performance	Rate: 0.94 per 1,000 population at risk. Bias: Some bias demonstrated
Risk Adjustment	Age, sex, DRG, comorbidity categories

Postoperative Physiologic and Metabolic Derangement

Definition	Cases of specified physiological or metabolic derangement per 1,000 elective surgical discharges.
Numerator	Discharges with ICD-9-CM codes for physiologic and metabolic derangements in any secondary diagnosis field per 1,000 elective surgical discharges. Discharges with acute renal failure (subgroup of physiologic and metabolic derangements) must be accompanied by a procedure code for dialysis (3995, 5498).
Denominator	All elective surgical discharges defined by admit type. Exclude patients with both a diagnosis code of ketoacidosis, hyperosmolarity, or other coma (subgroups of physiologic and metabolic derangements coding) and a principal diagnosis of diabetes. Exclude patients with both a secondary diagnosis code for acute renal failure (subgroup of physiologic and metabolic derangements coding) and a principal diagnosis of acute myocardial infarction, cardiac arrhythmia, cardiac arrest, shock, hemorrhage, or gastrointestinal hemorrhage. Exclude obstetrical patients in MDC 14.
Empirical Performance	Rate: 0.83 per 1,000 population at risk. Bias: Some bias demonstrated
Risk Adjustment	Age, sex, DRG, comorbidity categories

Postoperative Pulmonary Embolism or Deep Vein Thrombosis

Definition	Cases of deep vein thrombosis (DVT) or pulmonary embolism (PE) per 1,000 surgical discharges.
Numerator	Discharges with ICD-9-CM codes for deep vein thrombosis or pulmonary embolism in any secondary diagnosis field per 1,000 surgical discharges.
Denominator	All surgical discharges defined by specific DRGs. Exclude patients with a principal diagnosis of deep vein thrombosis. Exclude obstetrical patients in MDC 14. Exclude patients with secondary procedure code 38.7 when this procedure occurs on the day of or previous to the day of the principal procedure. Note: If day of procedure is not available in the input data file, the rate may be slightly lower than if the information was available.
Empirical Performance	Rate: 9.59 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted
Risk Adjustment	Age, sex, DRG, comorbidity categories

Postoperative Respiratory Failure

Definition	Cases of acute respiratory failure per 1,000 elective surgical discharges.
Numerator	All elective surgical discharges defined by admit type. Exclude patients with respiratory or circulatory diseases (MDC 4 and MDC 5). Exclude obstetrical patients in MDC 14.
Denominator	All elective surgical discharges defined by admit type. Exclude patients with respiratory or circulatory diseases (MDC 4 and MDC 5). Exclude obstetrical patients in MDC 14.
Empirical Performance	Rate: 3.64 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted
Risk Adjustment	Age, sex, DRG, comorbidity categories

Postoperative Sepsis

Definition	Cases of sepsis per 1,000 elective surgery patients, with length of stay more than 3 days.
Numerator	Discharges with ICD-9-CM code for sepsis in any secondary diagnosis field per 1,000 elective surgical discharge.
Denominator	All elective surgical discharges defined by admit type. Exclude patients with a principal diagnosis of infection, any code for immunocompromised state, or cancer. Include only patients with a length of stay of 4 days or more. Exclude obstetrical patients in MDC 14
Empirical Performance	Rate: 10.1 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted
Risk Adjustment	Age, sex, DRG, comorbidity categories

Postoperative Wound Dehiscence

Definition	Cases of reclosure of postoperative disruption of abdominal wall per 1,000 cases of abdominopelvic surgery.
Numerator	Discharges with ICD-9-CM code for reclosure of postoperative disruption of abdominal wall (5461) in any secondary procedure field per 1,000 eligible discharges.
Denominator	All abdominopelvic surgical discharges. Exclude obstetrical patients in MDC 14.
Empirical Performance	Rate: 1.95 per 1,000 population at risk. Bias: Some bias demonstrated
Risk Adjustment	Age, sex, DRG, comorbidity categories

Accidental Puncture or Laceration

Definition	Cases of technical difficulty (e.g., accidental cut or laceration during procedure) per 1,000 discharges.
Numerator	Discharges with ICD-9-CM code denoting technical difficulty (e.g., accidental cut, puncture, perforation, or laceration) in any secondary diagnosis field per 1,000 discharges.
Denominator	All medical and surgical discharges defined by specific DRGs. Exclude obstetrical patients in MDC 14.
Empirical Performance	Rate: 3.29 per 1,000 population at risk. Bias: Substantial bias; should be risk-adjusted
Risk Adjustment	Age, sex, DRG, comorbidity categories

Transfusion Reaction

Definition	Cases of transfusion reaction per 1,000 discharges.
Numerator	Discharges with ICD-9-CM code for transfusion reaction in any secondary diagnosis field per 1,000 discharges.
Denominator	All medical and surgical discharges defined by specific DRGs.
Empirical Performance	Rate: 0.01 per 1,000 population at risk. Bias: Did not undergo empirical testing of bias
Risk Adjustment	Age, sex, DRG, comorbidity categories

Birth Trauma/Injury to Neonate

Definition	Cases of birth trauma per 1,000 live born births.
Numerator	Discharges with ICD-9-CM code for birth trauma in any diagnosis field per 1,000 live born births.
Denominator	All live born births. Exclude infants with a subdural or cerebral hemorrhage (subgroup of birth trauma coding) and any diagnosis code of pre-term infant (denoting birth weight of less than 2,500 grams and less than 37 weeks gestation or 34 weeks gestation or less). Exclude infants with injury to skeleton (7673, 7674) and any diagnosis code of osteogenesis imperfecta (75651)
Empirical Performance	Rate: 6.34 per 1,000 population at risk. Bias: Did not undergo empirical testing of bias.
Risk Adjustment	Sex,

Obstetric Trauma/Cesarean Delivery

Definition	Cases of obstetric trauma (4th degree lacerations, other obstetric lacerations) per 1,000 Cesarean deliveries.
Numerator	Discharges with ICD-9-CM code for obstetric trauma in any diagnosis or procedure field per 1,000 Cesarean deliveries.
Denominator	All Cesarean delivery discharges.
Empirical Performance	Rate: 5.93 per 1,000 population at risk. Bias: Did not undergo empirical testing of bias
Risk Adjustment	Age

Obstetric Trauma/Vaginal Delivery with Instrument

Definition	Cases of obstetric trauma (4th degree lacerations, other obstetric lacerations) per 1,000 instrument-assisted vaginal deliveries.
Numerator	Discharges with ICD-9-CM code for obstetric trauma in any diagnosis or procedure field per 1,000 instrument-assisted vaginal deliveries.
Denominator	All vaginal delivery discharges with any procedure code for instrument assisted delivery
Empirical Performance	Rate: 235.7 per 1,000 population at risk. Bias: Did not undergo empirical testing of bias
Risk Adjustment	Age.

Obstetric Trauma/Vaginal Delivery without Instrument

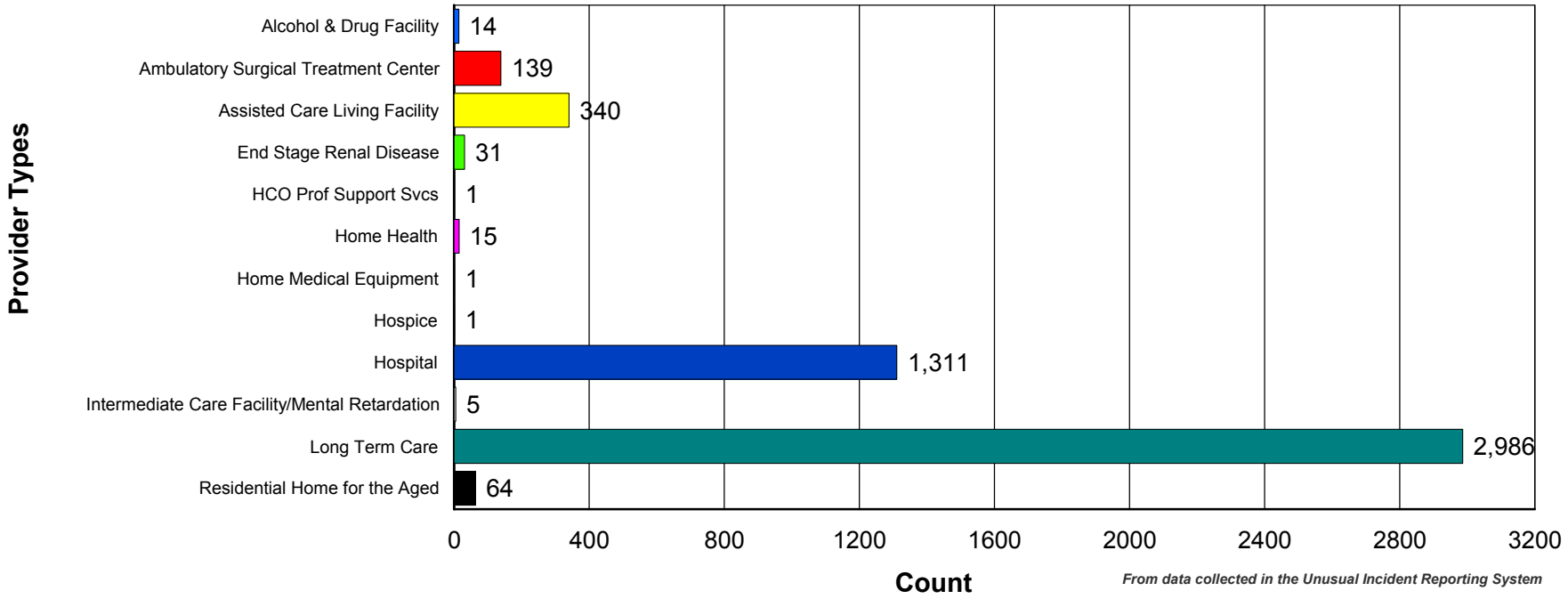
Definition	Cases of obstetric trauma (4th degree lacerations, other obstetric lacerations) per 1,000 vaginal deliveries without instrument assistance.
Numerator	Discharges with ICD-9-CM code for obstetric trauma in any diagnosis or procedure field per 1,000 vaginal deliveries without instrument assistance.
Denominator	All vaginal delivery discharges. Exclude instrument-assisted delivery.
Empirical Performance	Rate: 85.1 per 1,000 population at risk. Bias: Did not undergo empirical testing of bias
Risk Adjustment	Age

Source: *Patient Safety Indicators, Version 2.1, Revision 1*. March 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.qualityindicators.ahrq.gov/data/hcup/psi.htm

Reported Events from: 1/1/2004 to 12/31/2004
All Provider Types

Unusual Event Reports

Statewide Totals of Primary Occurrence Code by Provider Type



Printed: 5/10/2005

Occurrence Code Description	Total Occurrances	Percentage
901 - Other	1,475	30.05%
751 - Falls with Fractures	1,228	25.02%
968 - Physical Abuse	351	7.15%
808 - Post-Op Wd Infection	256	5.22%

964 - Altercations	**224**	**4.56%**
970 - Verbal Abuse	**190**	**3.87%**
801 - Repair/Removal of Organ	**166**	**3.38%**
803 - Hemorrhage/Hematoma	**151**	**3.08%**
819 - Unexpected Operation/RTOR	**132**	**2.69%**
915 - Death	**89**	**1.81%**
969 - Sexual Abuse	**79**	**1.61%**
936 - All Other Fires	**76**	**1.55%**
701 - Burns	**60**	**1.22%**
918 - Impairment of Limb	**43**	**0.88%**
972 - Misappropriation of Funds	**36**	**0.73%**
971 - Neglect/Self Neglect	**36**	**0.73%**
933 - Termination of Services	**36**	**0.73%**
913 - Retained Foreign Body	**34**	**0.69%**
806 - Displacement/Breakage of Device	**31**	**0.63%**
303 - Pneumothorax	**28**	**0.57%**
109 - Medication Near Death	**26**	**0.53%**
935 - Facility Fire	**25**	**0.51%**
923 - Elopement	**15**	**0.31%**
922 - Suicide/Attempted Suicide	**15**	**0.31%**
911 - Wrong Patient/Wrong Site Surgery	**14**	**0.29%**

602 - Peripheral Neurological	**12**	**0.24%**
601 - Neurological Deficit	**11**	**0.22%**
108 - Medication Harm	**10**	**0.20%**
301 - Necrosis/Infection	**10**	**0.20%**
932 - External Disaster	**9**	**0.18%**
917 - Loss of Limb or Organ	**7**	**0.14%**
966 - Restraint	**6**	**0.12%**
201 - Aspiration	**5**	**0.10%**
855 - Incorrect Procedure	**5**	**0.10%**
110 - Medication Death	**3**	**0.06%**
963 - Rape of Patient/Staff	**3**	**0.06%**
853 - Ruptured Uterus	**3**	**0.06%**
404 - Wrong Patient/Outdated Blood	**2**	**0.04%**
403 - Wrong Type Blood	**2**	**0.04%**
962 - Adult Abduction	**1**	**0.02%**
921 - Death From Crime or Serious Injury	**1**	**0.02%**
937 - Other Serious Events	**1**	**0.02%**
854 - Repair Circumcision	**1**	**0.02%**

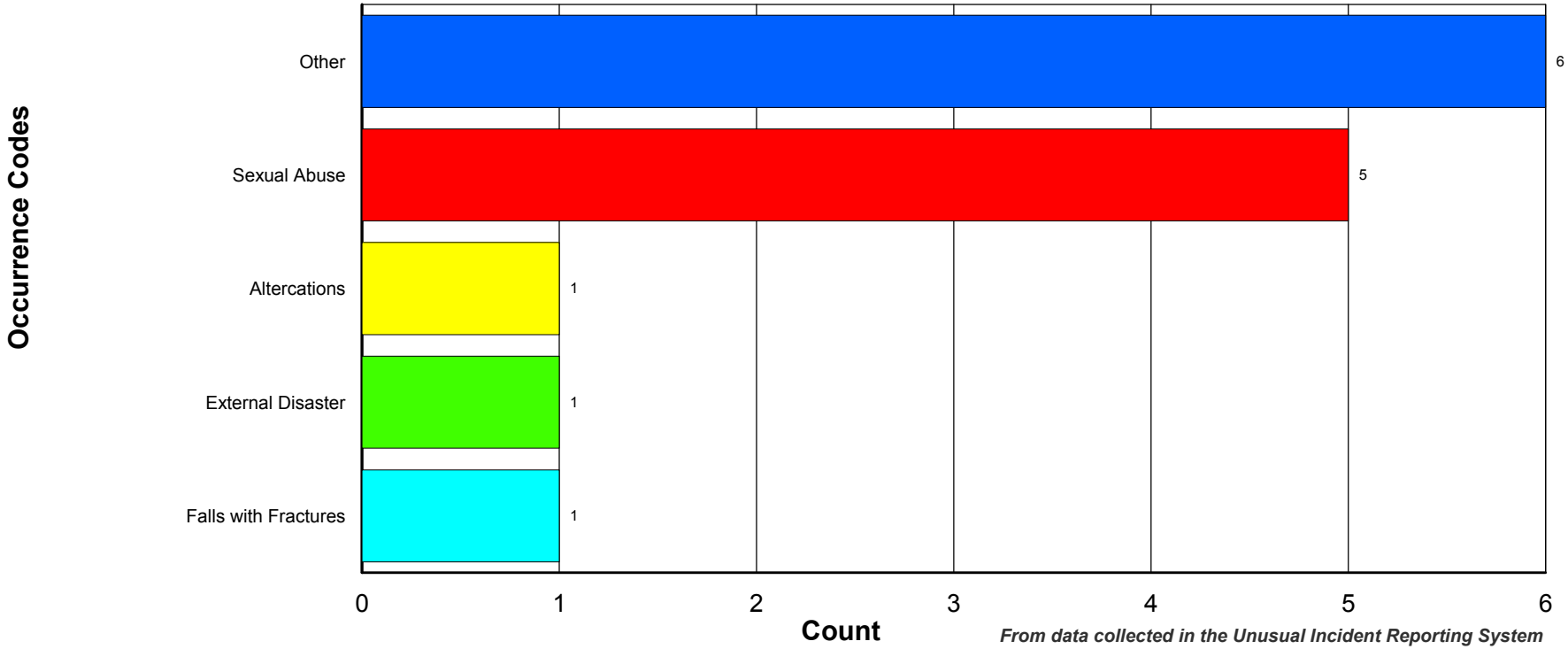
Total Statewide Occurences for All Provider Types: **4,908**

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Alcohol & Drug Facility

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
901 - Other	6	42.86%	1,475	0.41%
969 - Sexual Abuse	5	35.71%	79	6.33%
964 - Altercations	1	7.14%	224	0.45%
932 - External Disaster	1	7.14%	9	11.11%
751 - Falls with Fractures	1	7.14%	1,228	0.08%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

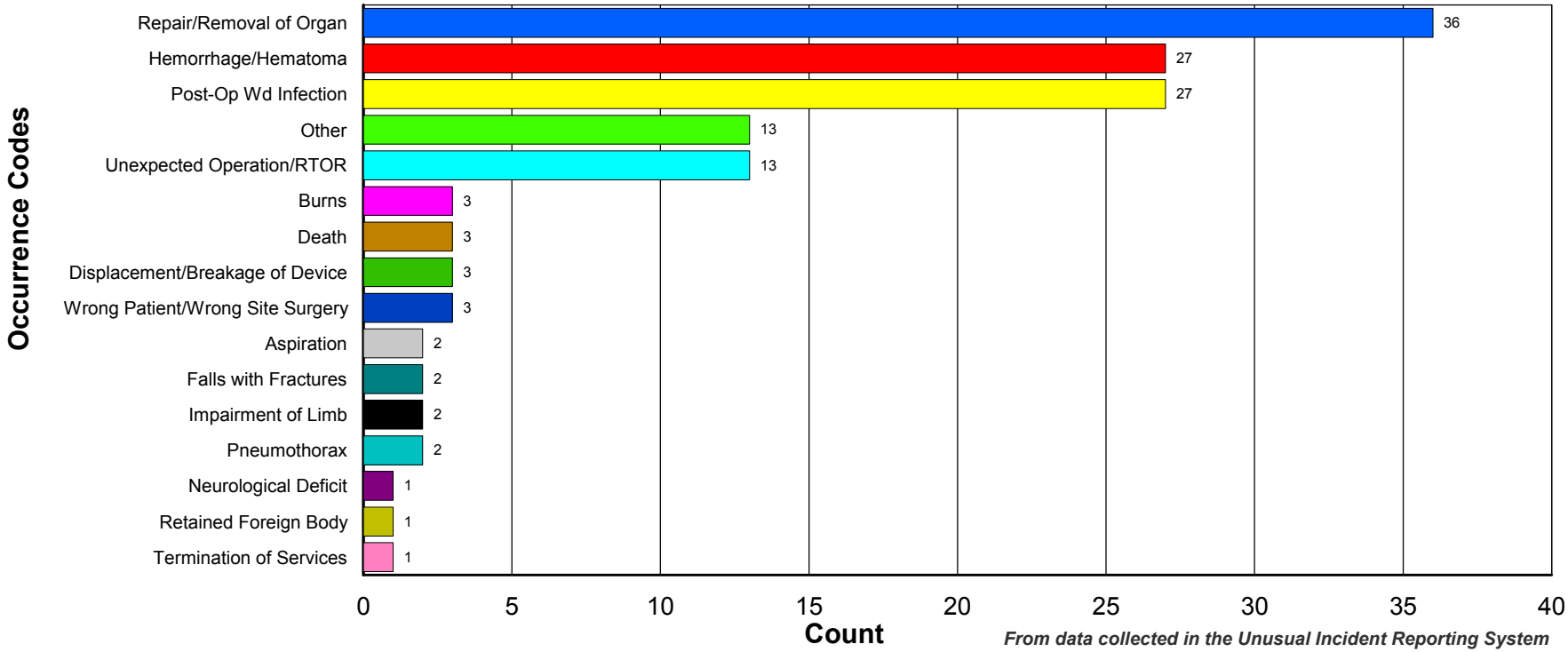
Total Occurrences for Provider Type: Alcohol & Drug Facility **14**
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Ambulatory Surgical Treatment Center

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
801 - Repair/Removal of Organ	36	25.90%	166	21.69%
803 - Hemorrhage/Hematoma	27	19.42%	151	17.88%
808 - Post-Op Wd Infection	27	19.42%	256	10.55%
901 - Other	13	9.35%	1,475	0.88%
819 - Unexpected Operation/RTOR	13	9.35%	132	9.85%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
701 - Burns	3	2.16%	60	5.00%
915 - Death	3	2.16%	89	3.37%
806 - Displacement/Breakage of Device	3	2.16%	31	9.68%
911 - Wrong Patient/Wrong Site Surgery	3	2.16%	14	21.43%
201 - Aspiration	2	1.44%	5	40.00%
751 - Falls with Fractures	2	1.44%	1,228	0.16%
918 - Impairment of Limb	2	1.44%	43	4.65%
303 - Pneumothorax	2	1.44%	28	7.14%
601 - Neurological Deficit	1	0.72%	11	9.09%
913 - Retained Foreign Body	1	0.72%	34	2.94%
933 - Termination of Services	1	0.72%	36	2.78%

Total Occurrences for Provider Type: Ambulatory Surgical Treatment Center **139**

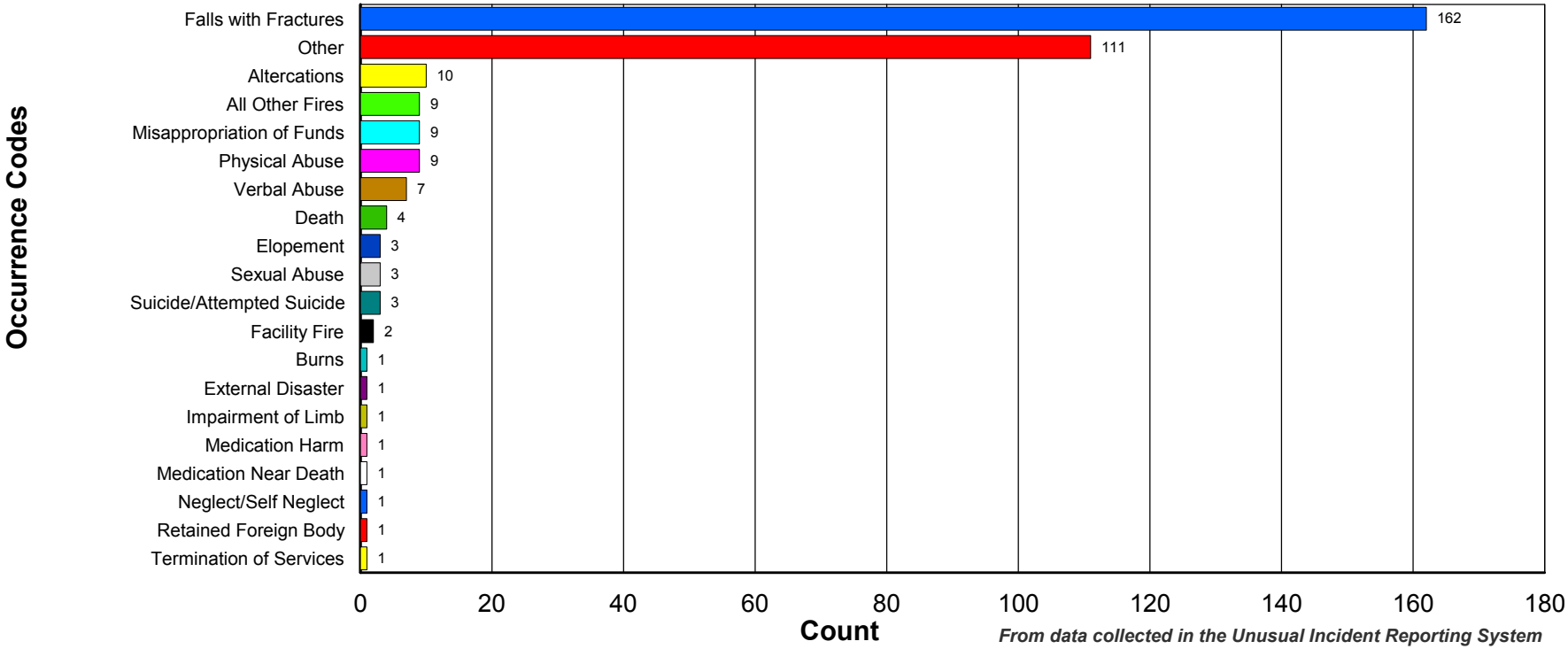
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Assisted Care Living Facility

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
751 - Falls with Fractures	162	47.65%	1,228	13.19%
901 - Other	111	32.65%	1,475	7.53%
964 - Altercations	10	2.94%	224	4.46%
936 - All Other Fires	9	2.65%	76	11.84%
972 - Misappropriation of Funds	9	2.65%	36	25.00%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
968 - Physical Abuse	9	2.65%	351	2.56%
970 - Verbal Abuse	7	2.06%	190	3.68%
915 - Death	4	1.18%	89	4.49%
923 - Elopement	3	0.88%	15	20.00%
969 - Sexual Abuse	3	0.88%	79	3.80%
922 - Suicide/Attempted Suicide	3	0.88%	15	20.00%
935 - Facility Fire	2	0.59%	25	8.00%
701 - Burns	1	0.29%	60	1.67%
932 - External Disaster	1	0.29%	9	11.11%
918 - Impairment of Limb	1	0.29%	43	2.33%
108 - Medication Harm	1	0.29%	10	10.00%
109 - Medication Near Death	1	0.29%	26	3.85%
971 - Neglect/Self Neglect	1	0.29%	36	2.78%
913 - Retained Foreign Body	1	0.29%	34	2.94%
933 - Termination of Services	1	0.29%	36	2.78%

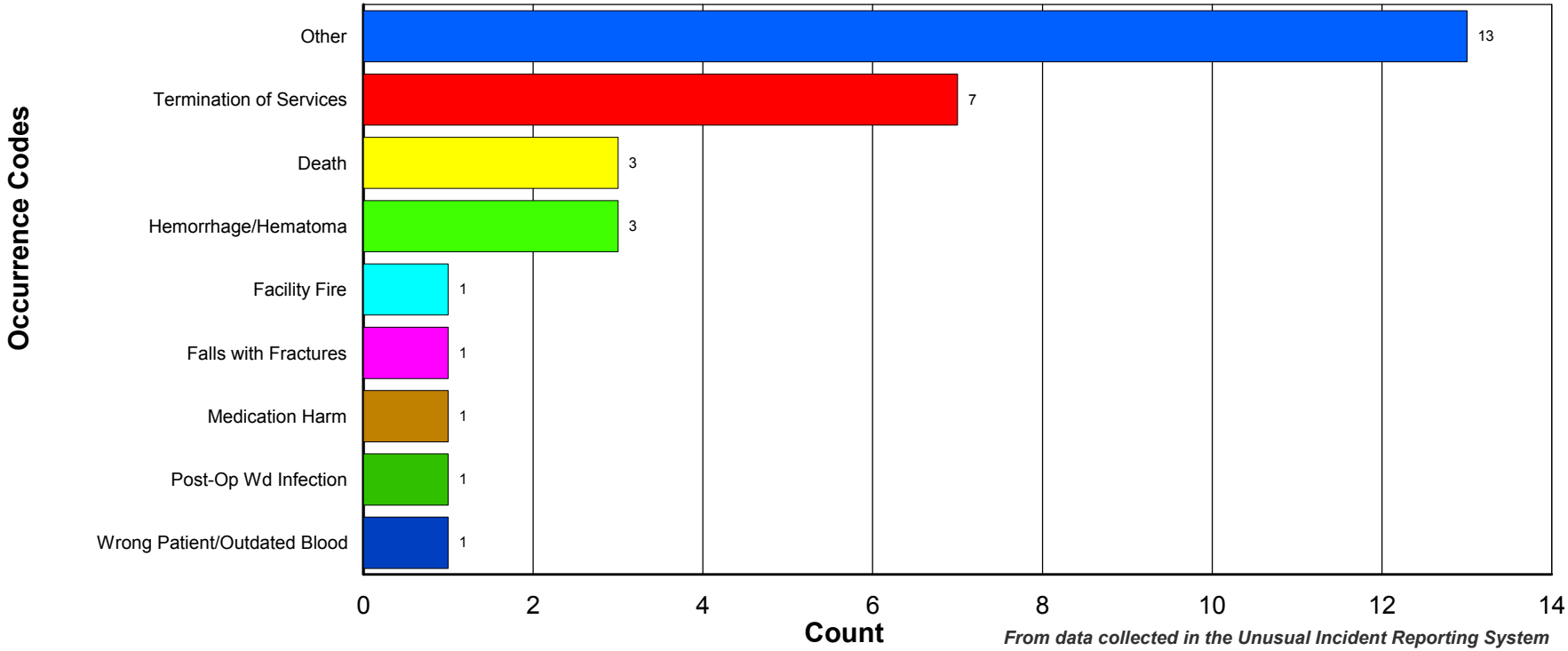
Total Occurrences for Provider Type: Assisted Care Living Facility **340**
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for End Stage Renal Disease

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
901 - Other	13	41.94%	1,475	0.88%
933 - Termination of Services	7	22.58%	36	19.44%
915 - Death	3	9.68%	89	3.37%
803 - Hemorrhage/Hematoma	3	9.68%	151	1.99%
935 - Facility Fire	1	3.23%	25	4.00%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
751 - Falls with Fractures	1	3.23%	1,228	0.08%
108 - Medication Harm	1	3.23%	10	10.00%
808 - Post-Op Wd Infection	1	3.23%	256	0.39%
404 - Wrong Patient/Outdated Blood	1	3.23%	2	50.00%

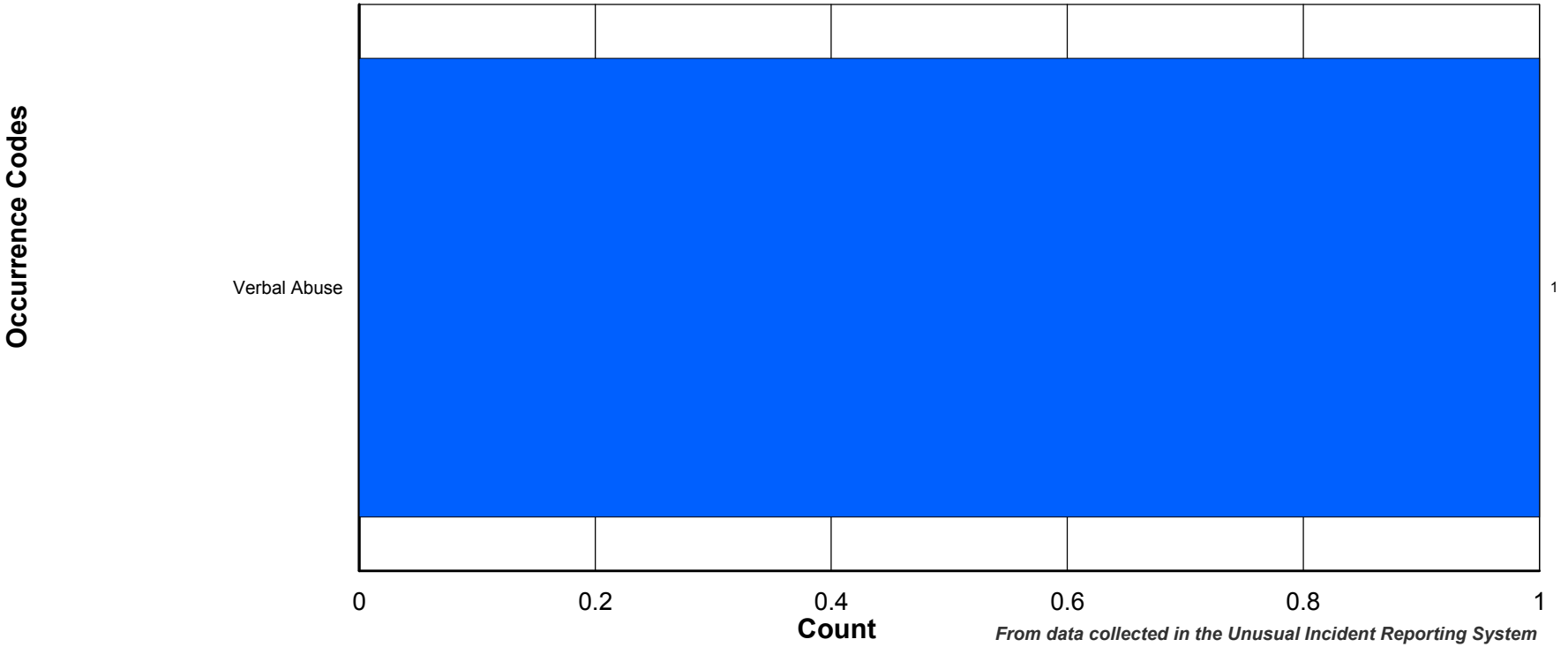
Total Occurrences for Provider Type: End Stage Renal Disease counting Reported Events from: 1/1/2004 to 12/31/2004 **31**

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for HCO Prof Support Svcs

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
970 - Verbal Abuse	1	100.00%	190	0.53%

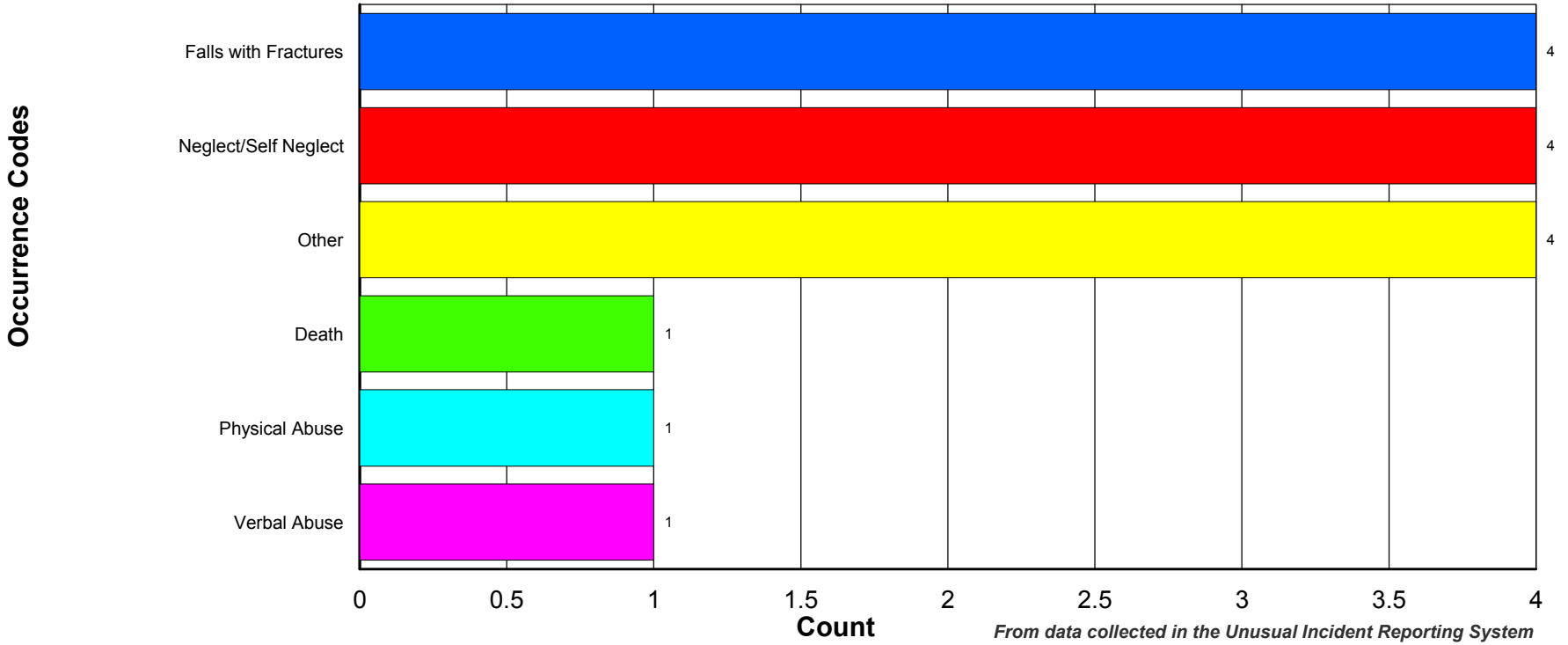
Total Occurrences for Provider Type: HCO Prof Support Svcs **1**
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Home Health

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
751 - Falls with Fractures	4	26.67%	1,228	0.33%
971 - Neglect/Self Neglect	4	26.67%	36	11.11%
901 - Other	4	26.67%	1,475	0.27%
915 - Death	1	6.67%	89	1.12%
968 - Physical Abuse	1	6.67%	351	0.28%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
970 - Verbal Abuse	1	6.67%	190	0.53%

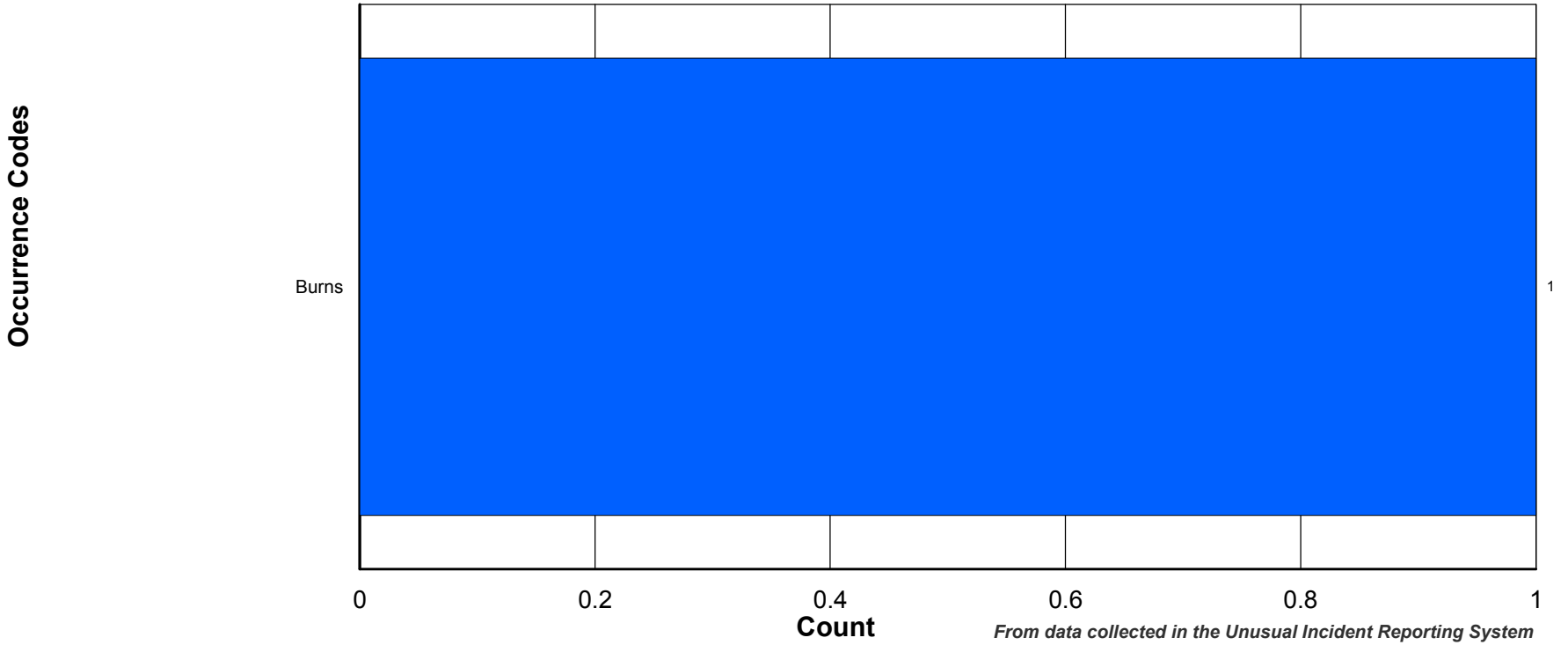
Total Occurrences for Provider Type: Home Health counting Reported Events from: 1/1/2004 to 12/31/2004 **15**

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Home Medical Equipment

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
701 - Burns	1	100.00%	60	1.67%

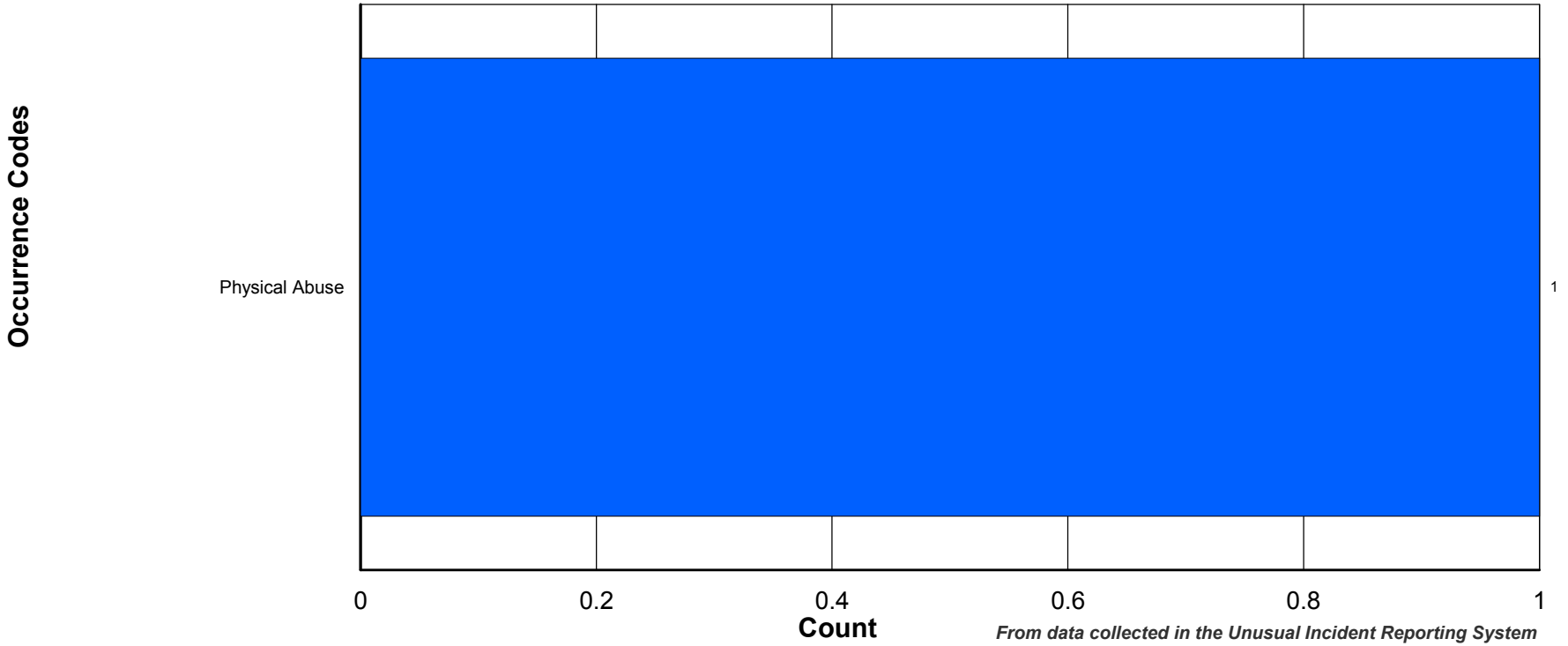
Total Occurrences for Provider Type: Home Medical Equipment counting Reported Events from: 1/1/2004 to 12/31/2004 **1**

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Hospice

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
968 - Physical Abuse	**1**	**100.00%**	**351**	**0.28%**

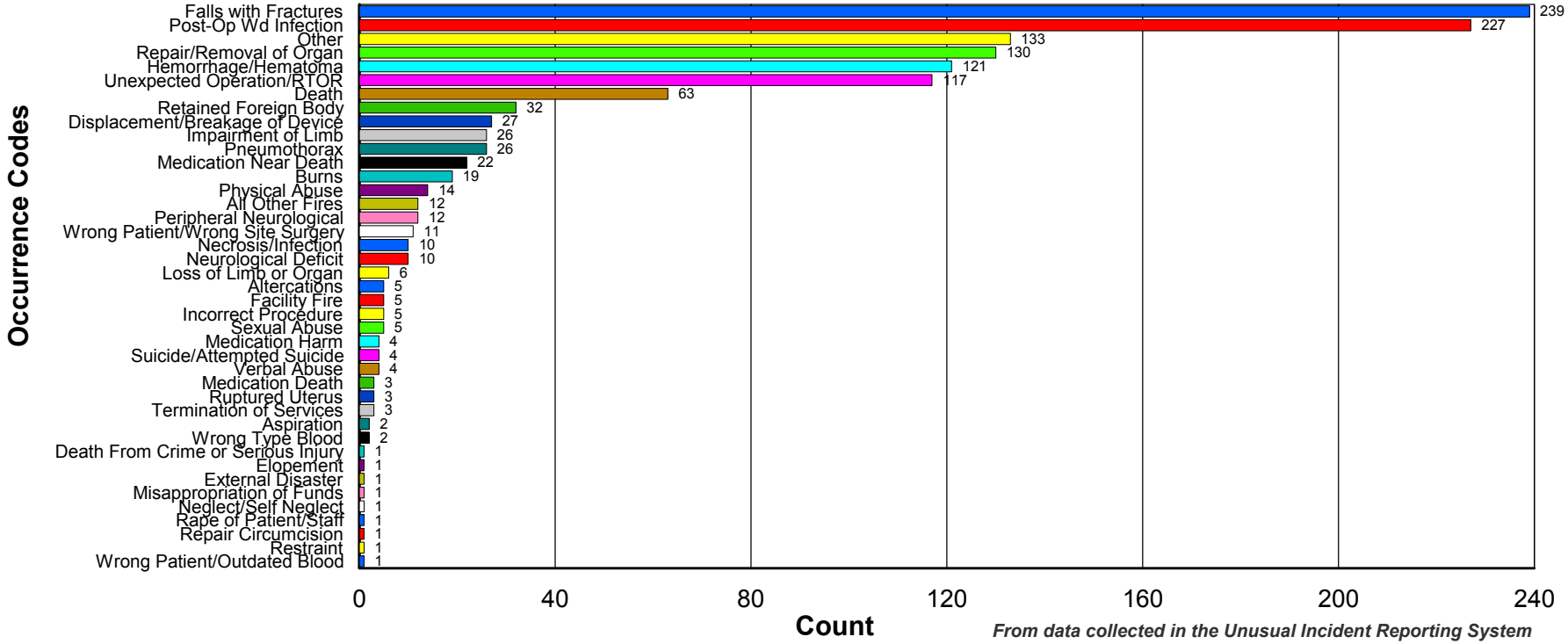
Total Occurrences for Provider Type: Hospice **1**
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Hospital

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
751 - Falls with Fractures	239	18.23%	1,228	19.46%
808 - Post-Op Wd Infection	227	17.32%	256	88.67%
901 - Other	133	10.14%	1,475	9.02%
801 - Repair/Removal of Organ	130	9.92%	166	78.31%
803 - Hemorrhage/Hematoma	121	9.23%	151	80.13%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
819 - Unexpected Operation/RTOR	117	8.92%	132	88.64%
915 - Death	63	4.81%	89	70.79%
913 - Retained Foreign Body	32	2.44%	34	94.12%
806 - Displacement/Breakage of Device	27	2.06%	31	87.10%
918 - Impairment of Limb	26	1.98%	43	60.47%
303 - Pneumothorax	26	1.98%	28	92.86%
109 - Medication Near Death	22	1.68%	26	84.62%
701 - Burns	19	1.45%	60	31.67%
968 - Physical Abuse	14	1.07%	351	3.99%
936 - All Other Fires	12	0.92%	76	15.79%
602 - Peripheral Neurological	12	0.92%	12	100.00%
911 - Wrong Patient/Wrong Site Surgery	11	0.84%	14	78.57%
301 - Necrosis/Infection	10	0.76%	10	100.00%
601 - Neurological Deficit	10	0.76%	11	90.91%
917 - Loss of Limb or Organ	6	0.46%	7	85.71%
964 - Altercations	5	0.38%	224	2.23%
935 - Facility Fire	5	0.38%	25	20.00%
855 - Incorrect Procedure	5	0.38%	5	100.00%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
969 - Sexual Abuse	5	0.38%	79	6.33%
108 - Medication Harm	4	0.31%	10	40.00%
922 - Suicide/Attempted Suicide	4	0.31%	15	26.67%
970 - Verbal Abuse	4	0.31%	190	2.11%
110 - Medication Death	3	0.23%	3	100.00%
853 - Ruptured Uterus	3	0.23%	3	100.00%
933 - Termination of Services	3	0.23%	36	8.33%
201 - Aspiration	2	0.15%	5	40.00%
403 - Wrong Type Blood	2	0.15%	2	100.00%
921 - Death From Crime or Serious Injury	1	0.08%	1	100.00%
923 - Elopement	1	0.08%	15	6.67%
932 - External Disaster	1	0.08%	9	11.11%
972 - Misappropriation of Funds	1	0.08%	36	2.78%
971 - Neglect/Self Neglect	1	0.08%	36	2.78%
963 - Rape of Patient/Staff	1	0.08%	3	33.33%
854 - Repair Circumcision	1	0.08%	1	100.00%
966 - Restraint	1	0.08%	6	16.67%
404 - Wrong Patient/Outdated Blood	1	0.08%	2	50.00%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

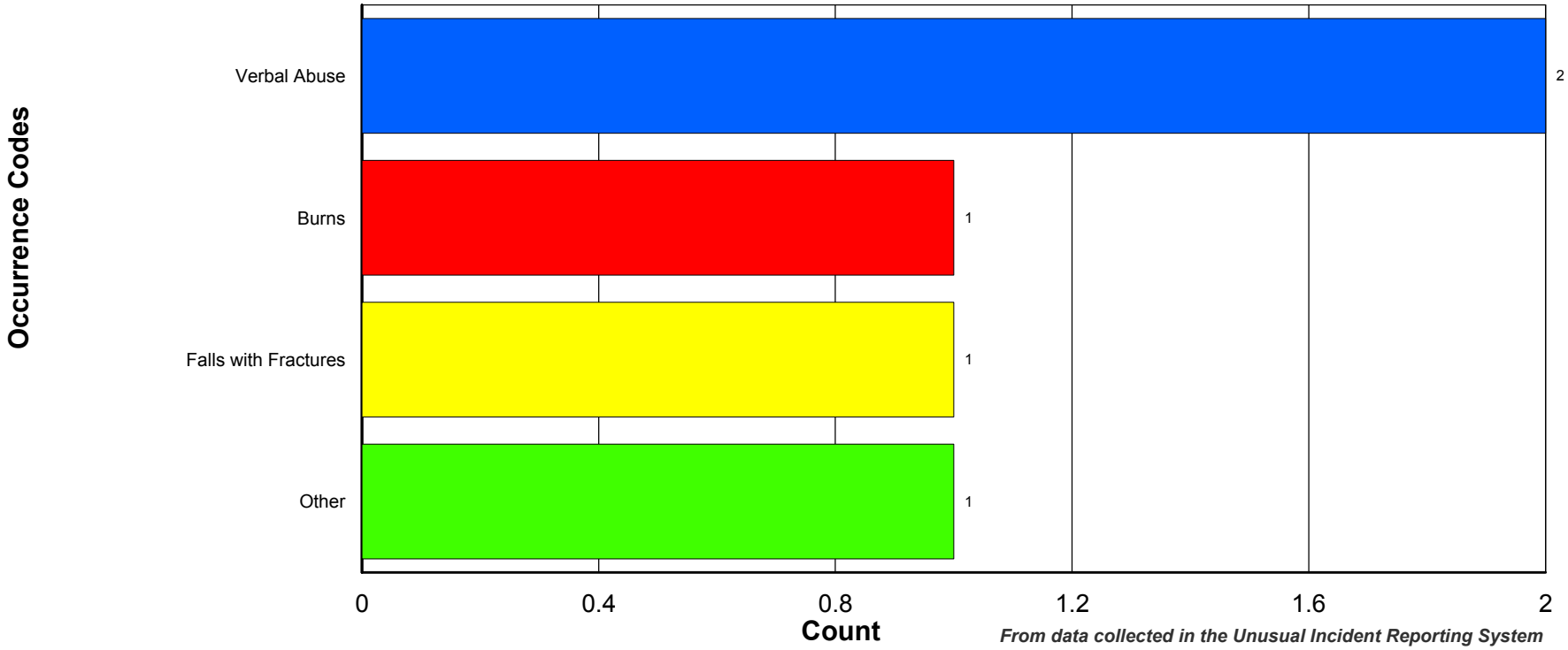
Total Occurrences for Provider Type: Hospital counting Reported Events from: 1/1/2004 to 12/31/2004	**1,311**

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Intermediate Care Facility/Mental Retardation

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
970 - Verbal Abuse	2	40.00%	190	1.05%
701 - Burns	1	20.00%	60	1.67%
751 - Falls with Fractures	1	20.00%	1,228	0.08%
901 - Other	1	20.00%	1,475	0.07%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Total Occurrences for Provider Type: Intermediate Care Facility/Mental Retardation **5**

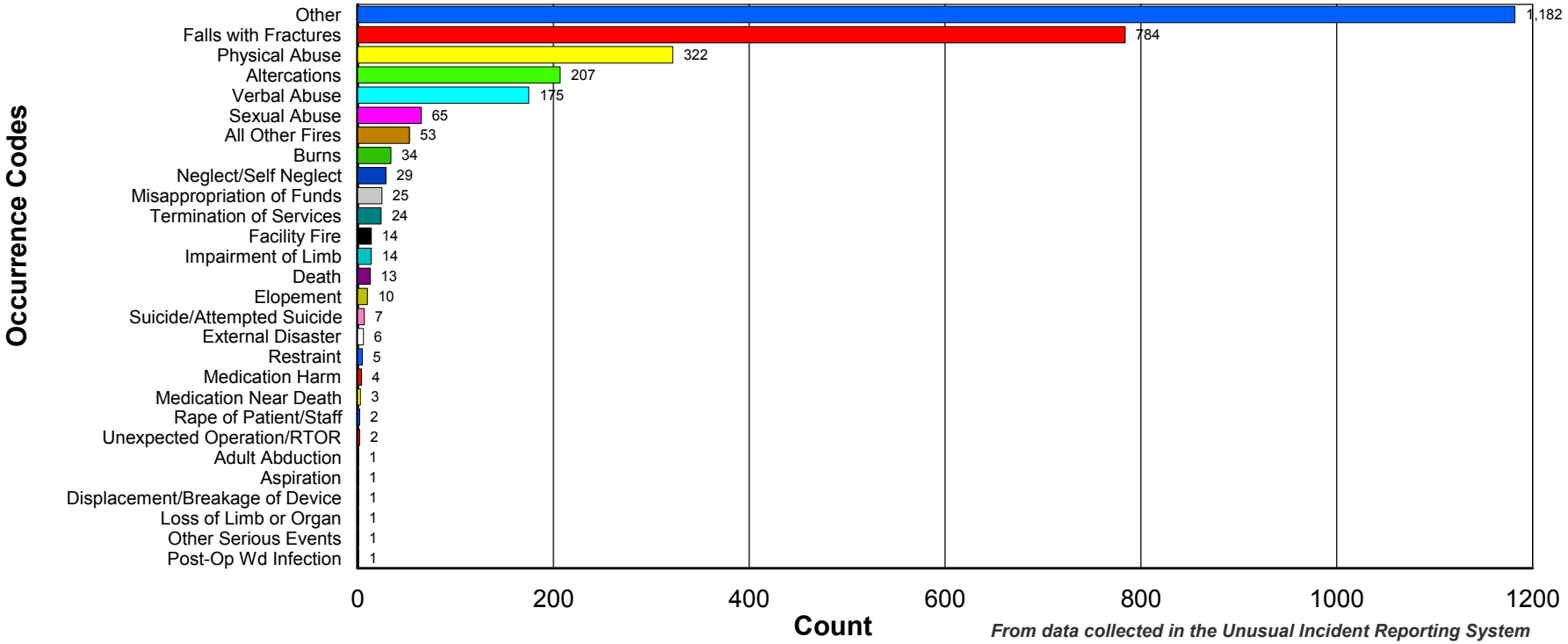
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Long Term Care

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
901 - Other	1,182	39.58%	1,475	80.14%
751 - Falls with Fractures	784	26.26%	1,228	63.84%
968 - Physical Abuse	322	10.78%	351	91.74%
964 - Altercations	207	6.93%	224	92.41%
970 - Verbal Abuse	175	5.86%	190	92.11%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
969 - Sexual Abuse	65	2.18%	79	82.28%
936 - All Other Fires	53	1.77%	76	69.74%
701 - Burns	34	1.14%	60	56.67%
971 - Neglect/Self Neglect	29	0.97%	36	80.56%
972 - Misappropriation of Funds	25	0.84%	36	69.44%
933 - Termination of Services	24	0.80%	36	66.67%
935 - Facility Fire	14	0.47%	25	56.00%
918 - Impairment of Limb	14	0.47%	43	32.56%
915 - Death	13	0.44%	89	14.61%
923 - Elopement	10	0.33%	15	66.67%
922 - Suicide/Attempted Suicide	7	0.23%	15	46.67%
932 - External Disaster	6	0.20%	9	66.67%
966 - Restraint	5	0.17%	6	83.33%
108 - Medication Harm	4	0.13%	10	40.00%
109 - Medication Near Death	3	0.10%	26	11.54%
963 - Rape of Patient/Staff	2	0.07%	3	66.67%
819 - Unexpected Operation/RTOR	2	0.07%	132	1.52%
962 - Adult Abduction	1	0.03%	1	100.00%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
201 - Aspiration	1	0.03%	5	20.00%
806 - Displacement/Breakage of Device	1	0.03%	31	3.23%
917 - Loss of Limb or Organ	1	0.03%	7	14.29%
937 - Other Serious Events	1	0.03%	1	100.00%
808 - Post-Op Wd Infection	1	0.03%	256	0.39%

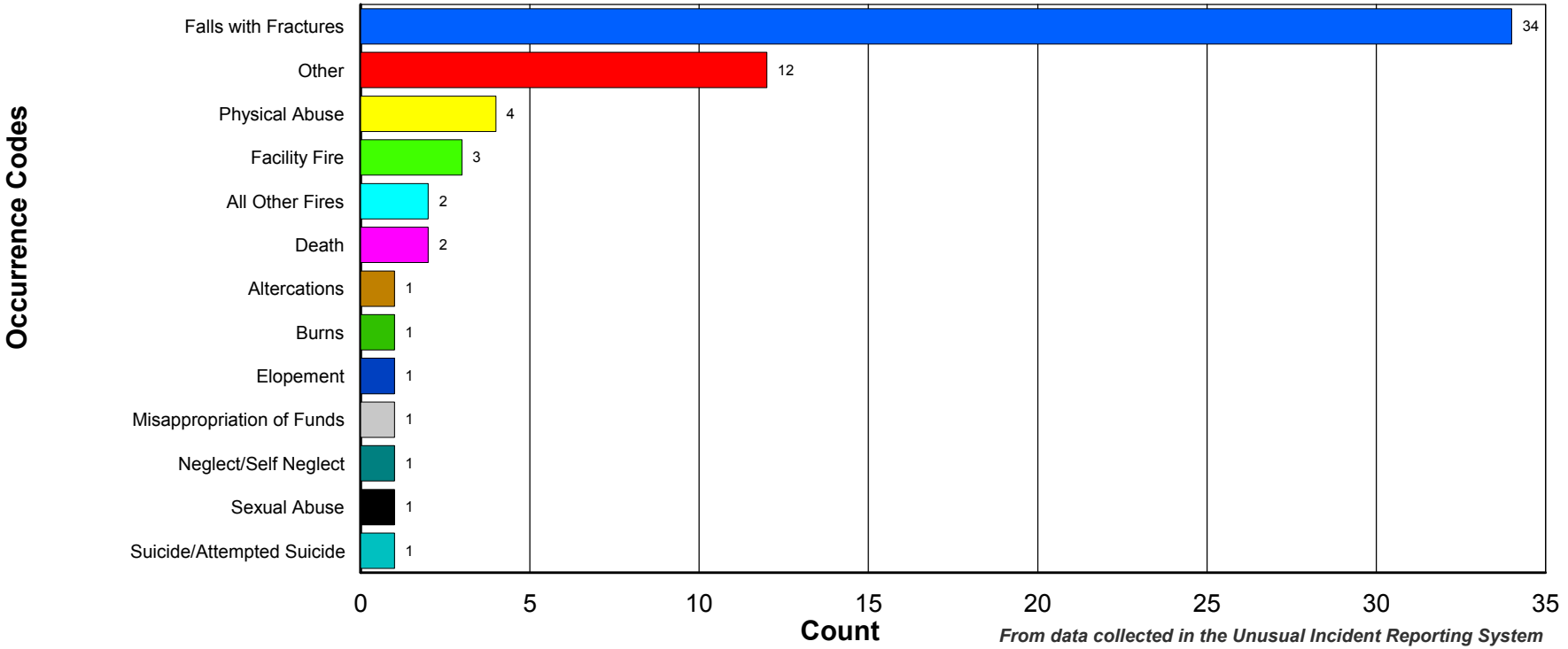
Total Occurrences for Provider Type: Long Term Care **2,986**
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Reported Events from: 1/1/2004 to 12/31/2004
for Residential Home for the Aged

Unusual Event Reports

Statewide Distribution of Primary Occurrence Code by Provider Type



From data collected in the Unusual Incident Reporting System

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
751 - Falls with Fractures	34	53.13%	1,228	2.77%
901 - Other	12	18.75%	1,475	0.81%
968 - Physical Abuse	4	6.25%	351	1.14%
935 - Facility Fire	3	4.69%	25	12.00%
936 - All Other Fires	2	3.13%	76	2.63%

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Occurrence Code Description	Total Occurrences	Percentage	Total Occurrences All Providers	Percentage of All Providers
915 - Death	2	3.13%	89	2.25%
964 - Altercations	1	1.56%	224	0.45%
701 - Burns	1	1.56%	60	1.67%
923 - Elopement	1	1.56%	15	6.67%
972 - Misappropriation of Funds	1	1.56%	36	2.78%
971 - Neglect/Self Neglect	1	1.56%	36	2.78%
969 - Sexual Abuse	1	1.56%	79	1.27%
922 - Suicide/Attempted Suicide	1	1.56%	15	6.67%

Total Occurrences for Provider Type: Residential Home for the Aged **64**
counting Reported Events from: 1/1/2004 to 12/31/2004

Please note that after a facility reports an event, only those events deemed "reportable" by the state are counted. To be reportable an event must result in patient harm. All "over reporting" is excluded. All events are counted by their report date and not date of occurrence. Only the primary occurrence code on a reported event is counted and secondary codes are ignored on this report. Complete descriptions of the occurrence codes can be found in the *Interpretive Guidelines for Reporting Unusual Events*.

Percentage of Facility Group Reporting over UIRS excluding Priority 5

5/10/2005 From 1/1/2004 to 12/31/2004 for All Regions

Alcohol & Drug Facility

1 of **294** Alcohol & Drug Facility(s) reported over the UIRS website. Therefore, **0.34%** have reported at least once over the website. **3** of **294** facilities of this type have incidents in the UIRS system at all, equaling **1.02%**. This includes reports by phone, fax, and mail in addition to web reports.

Ambulatory Surgical Treatment Center

25 of **144** Ambulatory Surgical Treatment Center(s) reported over the UIRS website. Therefore, **17.36%** have reported at least once over the website. **43** of **144** facilities of this type have incidents in the UIRS system at all, equaling **29.86%**. This includes reports by phone, fax, and mail in addition to web reports.

Assisted Care Living Facility

43 of **188** Assisted Care Living Facility(s) reported over the UIRS website. Therefore, **22.87%** have reported at least once over the website. **108** of **188** facilities of this type have incidents in the UIRS system at all, equaling **57.45%**. This includes reports by phone, fax, and mail in addition to web reports.

End Stage Renal Disease

11 of **123** End Stage Renal Disease(s) reported over the UIRS website. Therefore, **8.94%** have reported at least once over the website. **21** of **123** facilities of this type have incidents in the UIRS system at all, equaling **17.07%**. This includes reports by phone, fax, and mail in addition to web reports.

HCO Prof Support Svcs

1 of **158** HCO Prof Support Svcs(s) reported over the UIRS website. Therefore, **0.63%** have reported at least once over the website. **1** of **158** facilities of this type have incidents in the UIRS system at all, equaling **0.63%**. This includes reports by phone, fax, and mail in addition to web reports.

Home Health

6 of **156** Home Health(s) reported over the UIRS website. Therefore, **3.85%** have reported at least once over the website. **9** of **156** facilities of this type have incidents in the UIRS system at all, equaling **5.77%**. This includes reports by phone, fax, and mail in addition to web reports.

Home Medical Equipment

1 of **278** Home Medical Equipment(s) reported over the UIRS website. Therefore, **0.36%** have reported at least once over the website. **1** of **278** facilities of this type have incidents in the UIRS system at all, equaling **0.36%**. This includes reports by phone, fax, and mail in addition to web reports.

Percentage of Facility Group Reporting over UIRS excluding Priority 5

5/10/2005 From 1/1/2004 to 12/31/2004 for All Regions

Hospice

1 of **54** Hospice(s) reported over the UIRS website. Therefore, **1.85%** have reported at least once over the website. **1** of **54** facilities of this type have incidents in the UIRS system at all, equaling **1.85%**. This includes reports by phone, fax, and mail in addition to web reports.

Hospital

91 of **155** Hospital(s) reported over the UIRS website. Therefore, **58.71%** have reported at least once over the website. **111** of **155** facilities of this type have incidents in the UIRS system at all, equaling **71.61%**. This includes reports by phone, fax, and mail in addition to web reports.

Intermediate Care Facility/Mental Retardation

2 of **83** Intermediate Care Facility/Mental Retardation(s) reported over the UIRS website. Therefore, **2.41%** have reported at least once over the website. **2** of **83** facilities of this type have incidents in the UIRS system at all, equaling **2.41%**. This includes reports by phone, fax, and mail in addition to web reports.

Long Term Care

240 of **338** Long Term Care(s) reported over the UIRS website. Therefore, **71.01%** have reported at least once over the website. **315** of **338** facilities of this type have incidents in the UIRS system at all, equaling **93.20%**. This includes reports by phone, fax, and mail in addition to web reports.

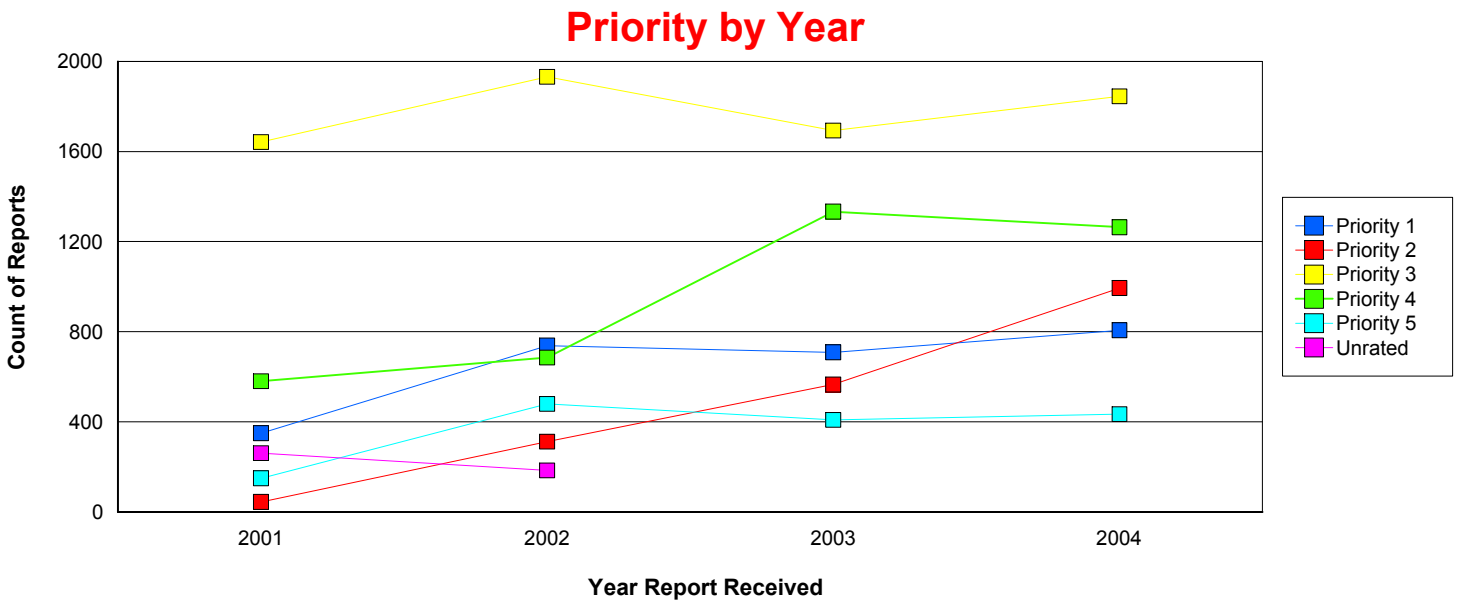
Residential Home for the Aged

10 of **137** Residential Home for the Aged(s) reported over the UIRS website. Therefore, **7.30%** have reported at least once over the website. **38** of **137** facilities of this type have incidents in the UIRS system at all, equaling **27.74%**. This includes reports by phone, fax, and mail in addition to web reports.

5/10/2005

UIRS Reports for Late Report Status for All Regions by Report Delay from 1/1/2004 to 12/31/2004

Confirmation	Facility Name	Fac Type	Category	Date of Occurence	Date of Report	Report Timing	Delay to Report	OC #1	Report Method
East Tennessee Region									
			Late Total: 721	**35.78%**					
			On Time Total: 1,294	**64.22%**					
			East Tennessee Region Grand Total: 2,015						
Middle Tennessee Region									
			Late Total: 455	**27.58%**					
			On Time Total: 1,195	**72.42%**					
			Middle Tennessee Region Grand Total: 1,650						
West Tennessee Region									
			Late Total: 526	**31.31%**					
			On Time Total: 1,154	**68.69%**					
			West Tennessee Region Grand Total: 1,680						



UIRS Reports from 1/1/2001 to 12/31/2004 by Method in All Regions

5/10/2005

Report Method	Percentage	Count
2001		
Priority 1	11.55%	350
Priority 2	1.49%	45
Priority 3	54.19%	1,642
Priority 4	19.17%	581
Priority 5	4.95%	150
Unrated	8.65%	262
	Total Reports:	3,030
2002		
Priority 1	17.05%	739
Priority 2	7.22%	313
Priority 3	44.55%	1,931
Priority 4	15.83%	686
Priority 5	11.08%	480
Unrated	4.27%	185
	Total Reports:	4,334
2003		
Priority 1	15.05%	709

UIRS Reports from 1/1/2001 to 12/31/2004 by Method in All Regions

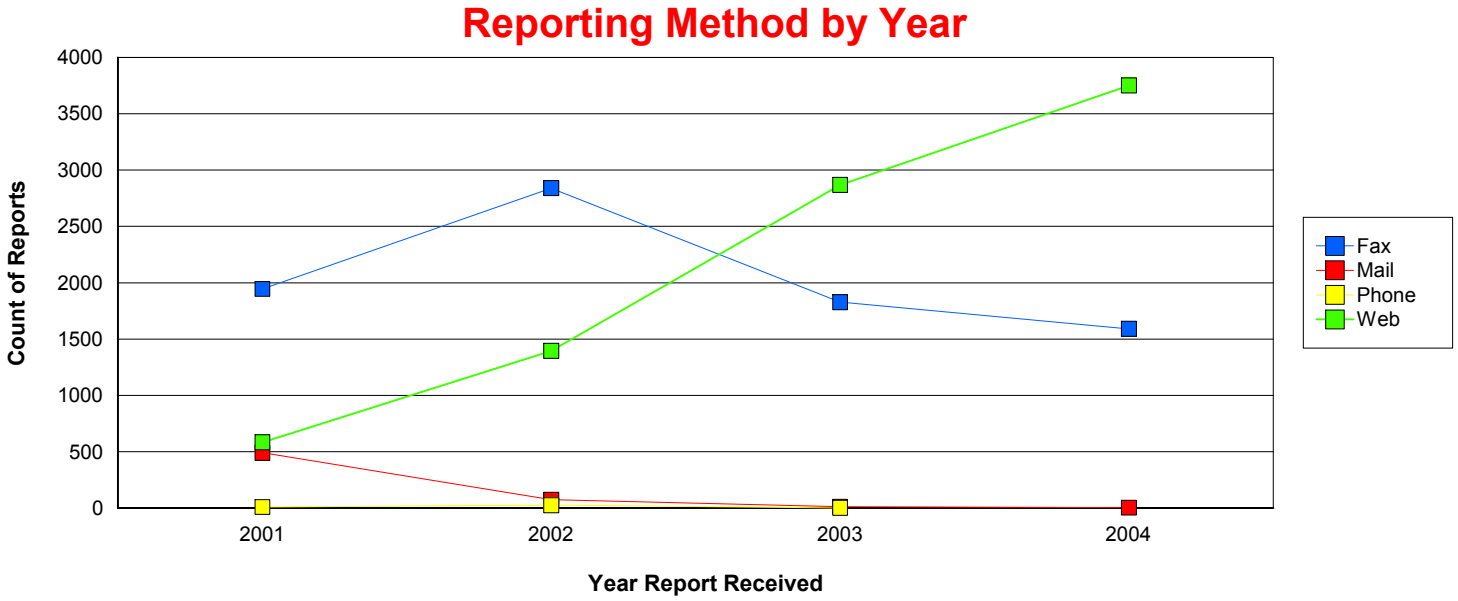
5/10/2005

Report Method	Percentage	Count
Priority 2	12.02%	566
Priority 3	35.94%	1,693
Priority 4	28.30%	1,333
Priority 5	8.68%	409
	Total Reports:	4,710

2004

Priority 1	15.10%	807
Priority 2	18.60%	994
Priority 3	34.52%	1,845
Priority 4	23.65%	1,264
Priority 5	8.14%	435
	Total Reports:	5,345

Grand Total: 17,419



UIRS Reports from 1/1/2001 to 12/31/2004 by Method in All Regions

5/10/2005

Report Method	Percentage	Count
2001		
Fax	64.19%	1,945
Mail	16.20%	491
Phone	0.33%	10
Web	19.27%	584
	Total Reports:	3,030
2002		
Fax	65.51%	2,839
Mail	1.71%	74
Phone	0.60%	26
Web	32.19%	1,395
	Total Reports:	4,334
2003		
Fax	38.79%	1,827
Mail	0.28%	13
Phone	0.04%	2
Web	60.89%	2,868
	Total Reports:	4,710
2004		

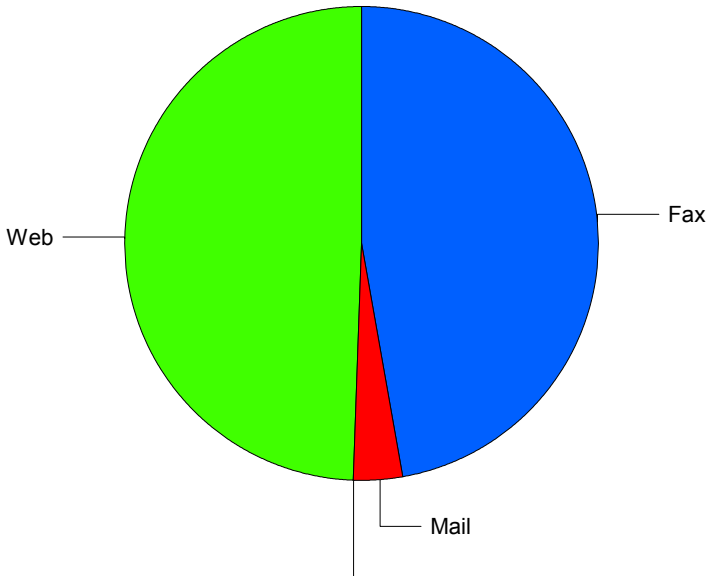
UIRS Reports from 1/1/2001 to 12/31/2004 by Method in All Regions

5/10/2005

Report Method	Percentage	Count
Fax	29.77%	1,591
Mail	0.07%	4
Web	70.16%	3,750
	Total Reports:	5,345

Grand Total: 17,419

Percentages of Reporting Method



Fax	47.1%
Mail	3.3%
Phone	0.2%
Web	49.4%
Total:	100.0%

UIRS Reports from 1/1/2001 to 12/31/2004 by Method in All Regions

5/10/2005

Report Received By	Percentage	Count
Fax	47.09%	8,202
Mail	3.34%	582
Phone	0.22%	38
Web	49.35%	8,597
Grand Total:		**17,419**